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Resident Physician

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Mediquiz CONTEST WINNERS

Special in this issue:

HOUSE STAFF INCOME TAX CLINIC

MARCH • 1961

In a series of 24 handicapped arthritics treated with dexamethasone for 8 to 16 months, ring size decreased consistently—objective evidence of antirheumatic effects which were maintained throughout the entire period of observation. Improvement was also noted in other antirheumatic indices, i. e., pain on motion, tenderness, swelling and morning stiffness.[1]

Supplied: as 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate and new Elixir DECADRON. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

Reference: 1. Bunim, J. J., in Hollander, J. L.: Arthritis and Allied Conditions, ed. 6, Philadelphia, Lea & Febiger, 1960, p. 364.

MERCK SHARP & DOHME
Division of Merck & Co., INC., West Point, Pa.

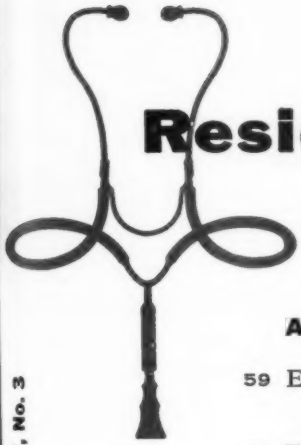
Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

March 1961, Vol. 7, No. 3

CONTENTS



Resident Physician

March 1961, Vol. 7, No. 3

Articles

The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. If undelivered, please send form 3547 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

in G.I., G.U. and Biliary SPASM

"Murel"-S.A.

Sustained Action Tablets

prompt, continuous and prolonged antispasmodic action for 6 to 9 hours with a single tablet

"MUREL" Advantages[1-4]

- Exceptionally effective clinically because three-way mechanism of action in one molecule (anticholinergic, musculotropic, ganglion-blocking) exerts synergistic spasmolytic effect
- Complementary action permits significantly low dosage and reduces reaction potential of any one mechanism
- Remarkably free from drug-induced complications such as mouth dryness, visual disturbances, urinary retention

Suggested Average Dosage: 40 to 80 mg. daily, depending on condition and severity. The higher range of dosage is usually required in spasm of the genitourinary and biliary tracts. One "Murel"-S.A. Sustained Action Tablet morning and evening. *When anxiety and tension are present,* "Murel" with Phenobarb-S.A. is suggested.

Available as: No. 315—"Murel"-S.A., 40 mg. Valethamate bromide; and No. 319—"Murel" with Phenobarb-S.A., with ½ gr. phenobarbital, present as the sodium salt. Both in bottles of 100 and 1,000.

Also available: "Murel" Tablets No. 314—10 mg. Valethamate bromide; "Murel" with Phenobarbital Tablets No. 318—10 mg. Valethamate bromide and ¼ gr. phenobarbital.

"Murel" Injectable No. 405—10 mg. Valethamate bromide per cc.

Precautions: As with other antispasmodic agents, caution should be exercised in patients with prostatic hypertrophy, glaucoma, and in the presence of cardiac arrhythmias.

References available on request.

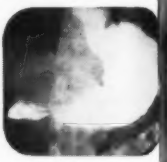
Ayerst®

AYERST LABORATORIES
New York 16, N. Y. • Montreal, Canada

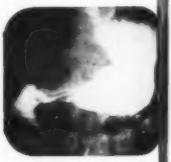
for acute, severe episodes
"MUREL" Injectable

Female patient, age 55, complaining of nausea and epigastric discomfort after meals.

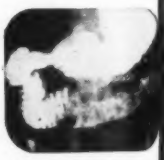
Diagnosis: Hiatus hernia and gastric ulcer.



1 hour after barium administration: Retention of barium due to spasticity of the gastric outlet, and incomplete visualization of the pylorus, duodenum and duodenal sweep. (Some barium has entered the small bowel.)



20 minutes after administration of "Murel" 2 cc. I.V.: Barium entering duodenum and duodenal sweep as spasticity is relieved.

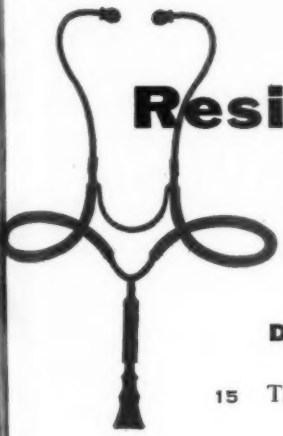


10 minutes later: Good filling of the gastric outlet as well as of the duodenal sweep.

Medical Records of Ayerst Laboratories 60[illegible]

March 1[illegible]

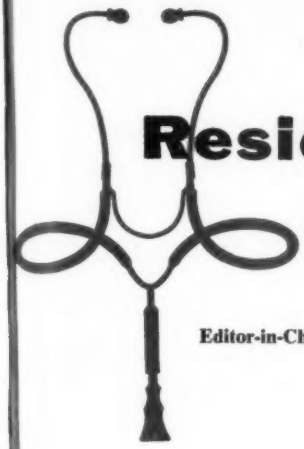
CONTENTS



Resident Physician

Departments

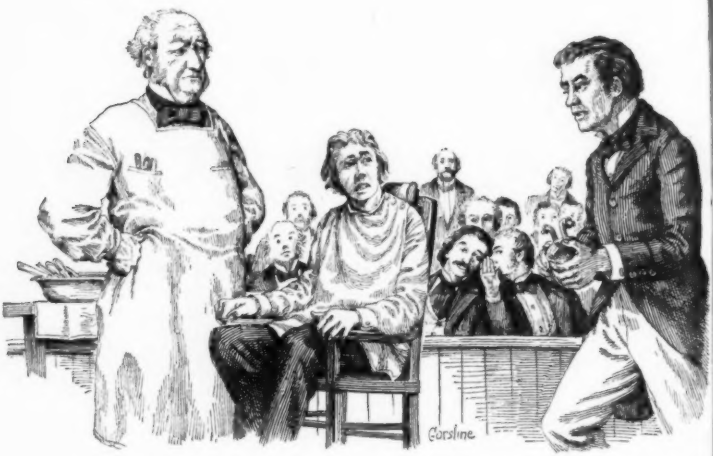
Journal for the Hospital Staff Officer



Resident Physician

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

West Coast Representative: Averill, Jackson & Associates, 232 North Lake Avenue, Pasadena, California. Subscription rate $10.00 per year. Single copies $1.00. Notify publisher promptly of change of address.



The Day Warren's Patient Didn't Scream

The morning of October 16, 1846 found the old operating amphitheater at the Massachusetts General Hospital packed with an expectant crowd of cynical spectators. On a chair in the "arena" sat the first patient, a frightened young man with a tumor afflicting the maxillary gland and part of the tongue. The surgeon, Dr. John Collins Warren, inured by years of experience to surgical suffering, lectured on the details of the case and then announced in a sarcastic tone, "We are going to test a preparation for which the astonishing claim has been made that it will render the person operated on free from pain." Here and there, laughter was heard in the audience, but it soon became mixed with comments of annoyance as the "anesthetist" failed to appear. Finally the door burst open and a harried young man rushed to the patient's side carrying a glass globe affixed with two glass nipples and filled with nitrous oxide. He was William Morton, a dentist; he had been delayed making last-minute adjustments in his equipment.

He inserted one nipple between the patient's lips and told him to breathe deeply. Soon the lips parted, the patient's eyes closed and his head fell to one side. "Sir, your patient is ready." Warren made the first incision—the patient did not stir. Astounded, Warren continued. There was utter silence in the hall as he scraped out the tumor, applied a ligature and stanched the bleeding. As he finished, just for a moment there were unguarded tears in his eyes, and he broke the silence with the words, "Gentlemen, this is no humbug."

—JURGEN THORWALD: *The Century of the Surgeon*, New York, Pantheon Books Inc., 1957, pp. 105-111.

Resident Physician

Anesthesiology

J. ADRIANI, M.D., Director, Department of Anesthesiology, Charity Hospital of New Orleans.

MAX S. SADOVE, M.D., Director, Department of Anesthesiology, University of Illinois.

Dermatology

MARION B. SULZBERGER, M.D., Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School.

General Practice

C. WESLEY EISELE, M.D., Chief, General Practice Residency Program, University of Colorado.

GEORGE ENTWISLE, M.D., General Practice Program, University Hospital, Baltimore.

Medicine

WILLIAM B. BEAN, M.D., Professor of Medicine, University of Iowa Medical School.

CHARLES DAVIDSON, M.D., Associate Professor of Medicine, Harvard Medical School.

C. WESLEY EISELE, M.D., Associate Professor of Medicine; Assistant Dean in Charge of Post Graduate Medical Education, University of Colorado.

CHARLES L. LEEDHAM, M.D., Director of Education, Cleveland Clinic, Frank E. Bunts Educational Institute.

JOHN C. LEONARD, M.D., Director, House Staff Education, Hartford Hospital.

Obstetrics-Gynecology

ALAN F. GUTTMACHER, M.D., Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

Ophthalmology

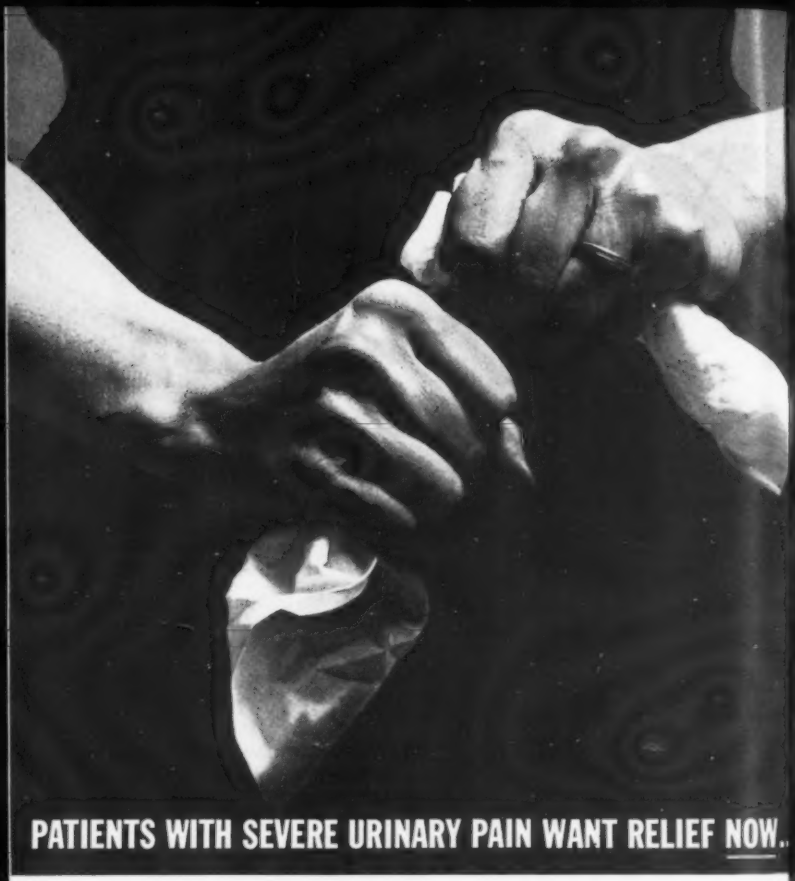
DERRICK T. VAIL, M.D., Chairman, Department of Ophthalmology, Northwestern University Medical School.

Orthopedics

HAROLD A. SOFIELD, M.D., Professor of Orthopedic Surgery, Northwestern University Medical School.

Otolaryngology

DEAN M. LIERLE, M.D., Chief, Department of Otolaryngology and Maxillofacial Surgery, State University of Iowa.



PATIENTS WITH SEVERE URINARY PAIN WANT RELIEF NOW.

Rx PYRIDIUM®

brand of phenylazo-diamino-pyridine HCl

Two Pyridium tablets t.i.d., prescribed along with any antibacterial of your choice, relieve the pain of urinary infection in only 30 minutes. During the first 3 to 4 days of therapy, Pyridium will make your patient comfortable until the antibacterial reduces inflammation and controls the infection.

AVERAGE DOSE: Adults—2 tablets t.i.d. Children 9 to 12—1 tablet t.i.d. SUPPLIED: 0.1 Gm. tablets, bottles of 50. PRECAUTIONS: Pyridium is contraindicated in patients with renal insufficiency and/or severe hepatitis. *Full dosage information, available on request, should be consulted before initiating therapy.*

WARNER CHILCOTT

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JAMES MARVIN BATY, M.D., Physician-in-Chief, Boston Floating Hospital.

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HERMAN E. HILLEBOE, M.D., Commissioner of Health, State of New York.

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KARL A. MEYER, M.D., Chairman, Department of Surgery, Cook County Hospital.

HOWARD E. SNYDER, M.D., The Snyder Clinic, Winfield, Kansas.

Thoracic Surgery

PAUL C. SAMSON, M.D., Associate Clinical Professor, Stanford University School of Medicine.

Urology

HERBERT B. WRIGHT, M.D., Chief of Urology, Evangelical Deaconess Hospital, Cleveland.

Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

COUMADIN

the proven anticoagulant for long-term maintenance

now more widely prescribed than all other oral anticoagulants combined

152,000,000
Over ~~131,000,000~~ doses administered to date

Over 125 published papers since 1953

the original and only warfarin responsible for establishing this drug as closely approaching the ideal anticoagulant.[1,2]

1. Baer, S., et al.: J.A.M.A. 167:704, June 7, 1958. 2. Moser, K. M.: Disease-a-Month, Chicago, Yr. Bk. Pub., Mar., 1960, p. 13.

Full range of oral and parenteral dosage forms —

COUMADIN* (warfarin sodium) is available as: Scored tablets — 2 mg., lavender; 5 mg., peach; 7½ mg., yellow; 10 mg., white; 25 mg., red. Single Injection Units — one vial, 50 mg., and one 2 cc. ampul Water for Injection; one vial, 75 mg., and one 3 cc. ampul Water for Injection.

Average Dose: Initial, 40-60 mg. For elderly and/or debilitated patients, 20-30 mg. Maintenance, 5-10 mg. daily, or as indicated by prothrombin time determinations.

*Manufactured under license from the Wisconsin Alumni Research Foundation.

Complete Information and Reprints on Request

Endo ENDO LABORATORIES
Richmond Hill 18, New York

Viewbox Diagnosis

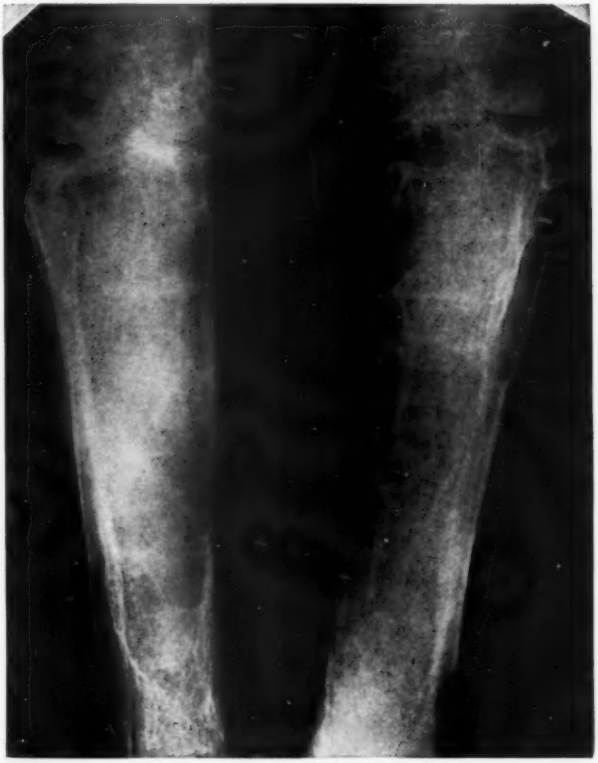
Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University-College of Medicine
and Director of Radiology, Bellevue Hospital Center

Fifty-five-year-old male. Chief complaints: Swelling of the extremities, skin pigmentations, difficulty in walking.

What is your diagnosis?

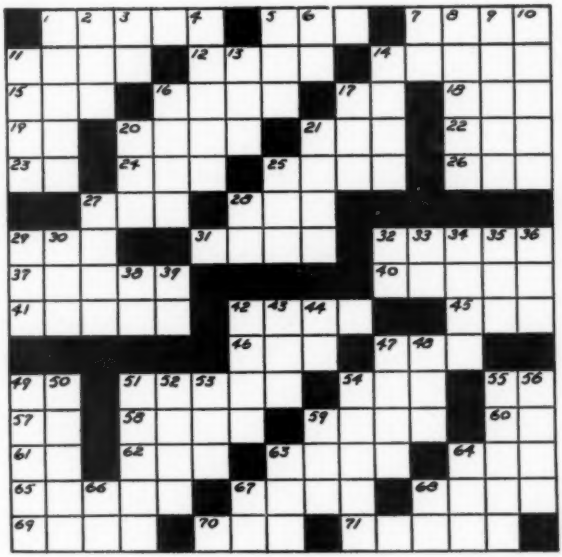
1. Paget's disease
2. Fibrous dysplasia
3. Osteomyelitis
4. Osteogenesis Imperfecta

(Answer on page 182)



Resident Relaxer

(Solution on page 182)



ACROSS

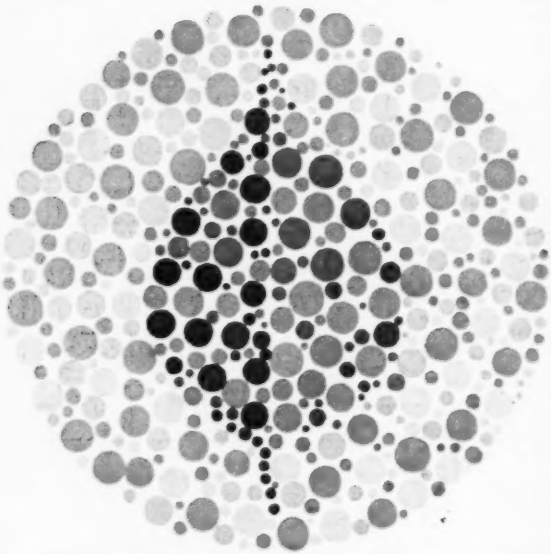
1. Stage of a disease
5. Solution (Abbr.)
7. Powdered soapstone
11. Lower lateral nasal cartilage
12. Syringe
14. Metal mixture
15. Illness (Fr.)
16. Competent
17. Before meals (Lat. Abbr.)
18. N_2O is one
19. Old Tuberculin
20. Stop
21. A metal
22. —Idoate, Poison Remedy
23. Concerning
24. In what manner
25. Crippled
26. Within (Comb. form)
27. Useful bean
28. Sheet of India rubber
29. Also
31. Crumb (Lat.)
32. Pertaining to part of the pelvis
37. Pertaining to birds
40. Skin
41. Abnormal respiratory sounds
42. Amount of medicine
45. Cereal
46. Thoracic bone
47. Homo Sapiens
49. Blood pressure
50. Pertaining to the nose
54. Baglike organ
55. Celium (Symb.)
58. Cheese
59. Sing gayly
60. Atop
61. Like
62. Fetal position: abbr.
63. Without (Lat.)
64. ——Pecia, Baldness
65. Bennett's fracture
67. Sodium Bicarbonate
68. Implement
69. Distant (Prefix)
70. Salt
71. Citrus Fruit

DOWN

1. Flattened surface
2. Man's name
3. Argon (Sym.)
4. Joint
5. Perceive
6. Conjunction
7. Thallium (Sym.)
8. Seaweed (Pl.)
9. Lends
10. ——Scopy, bladder examination
11. Love
13. Gingiva
14. Inflammatory disease of the sebaceous glands
16. Nautical hello
17. Direct
20. Health Organization of the U. N.
21. Swelling of the feet and legs
25. Milklike medicine
27. Defile
28. Twice (Prefix)
29. Coal derivative used in ointments
30. Eggs
32. The True Unconscious (Freud)
33. Article (Fr.)
34. Anti-Anemia factor
35. Medical society
36. Animal used in bioassay of digitalis
38. Antitoxic unit (German)
39. Q. —— not enough (Lat.)
42. Apothecaries' unit of weight
43. Liquid fat
44. Tin (Sym.)
47. Producer of spermatozoa
48. Deed
49. Nucleated erythrocyte
50. Soft viscid substance
51. Transmitter of impulses
52. Add (Latin)
53. Natural juice of a living structure
54. Pertaining to a cavity
55. Part of the intestine
56. Tautomeric form
59. Top
63. Liquid colloid solution
64. Anodal opening odor (Abbr.)
66. Aluminum (Sym.)
67. According to art (Latin)
68. Temporomandibular (Abbr.)

"SEEING YELLOW" ON DIGITALIS LEAF 61-year old male with syphilitic heart disease, cardiac enlargement Grade II, sinus rhythm, right bundle block and aortic insufficiency. Evaluated to be in class III-C. For 11 months, he took 0.1 Gm. of digitalis leaf daily. Admitted to hospital because of nausea, vomiting and disturbance in color-vision. Medication was discontinued for 30 days, after which he was redigitalized with digitoxin and discharged on 0.1 Gm. digitalis leaf daily. Four days later he was readmitted with nausea, vomiting, disturbed color-vision. Digitalis again discontinued for 5 days and toxic symptoms disappeared. Patient then placed on GITALIGIN, 0.5 mg. per day. There were no toxic signs or symptoms and failure was well controlled.[1]

"DIGITALIS TOXICITY IS SEEN WITH INCREASING FREQUENCY TODAY..."[2]



for maximal digitalis activity with minimal toxicity

Gitaligin®†

"...patients who became toxic very readily with other agents could later be satisfactorily digitalized with gitalin (GITALIGIN)."[2] Wider margin of safety—frequently effective in patients refractory to other digitalis glycosides • broader clinical utility—therapeutic dose only ⅓ the toxic dose • faster rate of elimination than digitoxin or digitalis leaf. ☐ Supplied: 0.5 mg. scored tablets—bottles of 30 and 100.

1. Dimitroff, S. P. et al.: Ann. Int. Med. 39:1189, 1953. 2. Pastor, B. H.: GP 22:85, 1960.

†amorphous gitalin, White

White WHITE LABORATORIES, INC. • Kenilworth, New Jersey

PARAFON

(PARAFLEX® + TYLENOL®)

for relief of pain and muscle spasm

Winter activity often calls soft and unused muscles into play. To relieve the frequently painful consequences, a logical choice is PARAFON. Combining a superior muscle relaxant with a preferred musculoskeletal analgesic, PARAFON promptly alleviates pain and stiffness, restores mobility, and accelerates recovery. Just 2 tablets provide up to 6 hours of relief. PARAFON is effective in musculoskeletal disorders, such as sprains, strains, myositis, whiplash injuries, low back pain, and fibrositis. Side effects are rare, almost never require cessation of therapy.

Dosage: Two tablets t.i.d. or q.i.d.

Supplied: Scored, pink tablets, bottles of 50. Each tablet contains PARAFLEX® Chlorzoxazone† 125 mg., and TYLENOL® Acetaminophen 300 mg.

†U.S. Patent No. 2,895,877

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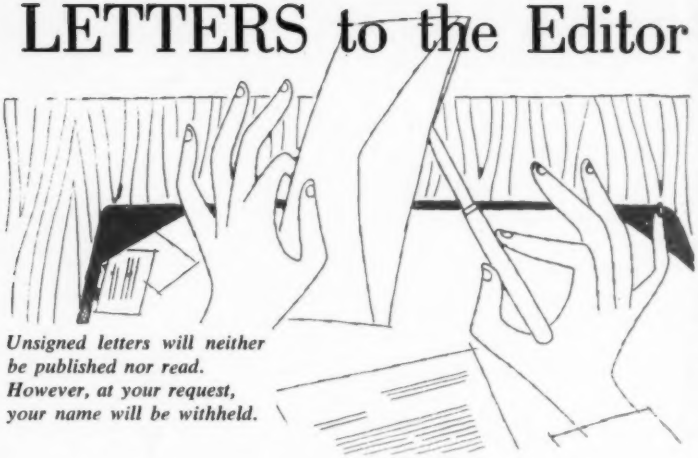
LETTERS to the Editor



Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Mediquiz® Contest

. . . Win or lose, your contest was a wonderful idea. It gave me the spark to really dig into the library . . .

R. B. Sayre, M.D.
NEW YORK CITY, N. Y.

. . . to let you know that "It Pays to Read," was true in my case. I became familiar with journals outside my own specialty for the first time. I've gotten excited again about the marvelous possibilities of medicine. This alone was well worth the time invested on your damnable, devilishly designed questions. So mark me down as a happy loser.

• *The editor thought it best to withhold the name of the author of the above letter since he actually won one of the* MEDIQUIZ® CONTEST *prizes. He was notified of this fact just before we went to press—as were all other winning contestants.* *See page 69 for details.*

Oh Those College Fees!

As an attendant at a teaching hospital in New York City, I have the opportunity to read your journal from time to time. (The thought often strikes me that I could have made good use of just such a journal when I took my residency. I know I would have saved myself money and frustra-

—Continued on page 46

AN EFFECTIVE, FLEXIBLE PLAN

The Carnation Weight Reduction Plan provides balanced nutrition. Providing 1000 calories a day, the Plan gives the dieter 70 grams of high-quality, hunger-appeasing protein. This concentration of protein helps satisfy the appetite, and at the same time, keeps up the dieter's energy. The Plan meets the Daily Adult Requirement for all vitamins and minerals with established minimums.

The physician prescribes the multi-vitamin-mineral preparation to supply the vitamin-mineral elements outside the basic food drink. The physician may also wish to vary the number of meals the dieter replaces with the Carnation Plan Formula and the number of days the patient stays on the regimen. In this way the physician is given the opportunity to adjust the regimen of the dieter to suit the needs of each individual patient.

BULK – TO PROTECT AGAINST CONSTIPATION

Dieters can snack with low-calorie vegetables and greens like celery, cucumbers, radishes, green pepper, lettuce. These snacks are welcomed by the dieter, and they aid regularity. Coffee and tea (without sugar and cream) may be used. Plenty of water is generally recommended.

FOR ALL DIET-CONSCIOUS PATIENTS

Carnation Nonfat Dry Milk can be recommended apart from a meal-replacement diet. All patients interested in weight control can get important protein, calcium, and B-vitamins the low-calorie way. Only 81 calories in an 8-ounce glass of regular Carnation Instant Nonfat Dry Milk.

FOR CONVENIENCE: CARNATION WEIGHT REDUCTION PLAN FOLDERS FOR YOUR PATIENTS

They describe the Plan fully, concisely. Give complete directions. Save your valuable time. Generous supply of folders in unique tear-out pad. Simply write to Carnation Company. Dept. MLI, Los Angeles 19, Calif.

Four glasses of the Carnation Weight Reduction Formula and the vitamin-mineral supplement* answer the Minimum Daily Adult Requirement for all known vitamins and minerals. Besides 70 grams of high-quality protein, 100 grams of carbohydrate, and 36.8 grams of fat, the Carnation Weight Reduction Plan provides:

		Multiples of M.D.R.
Vitamin A	6540 Units	1.3
Vitamin D	500 Units	1.2
Ascorbic Acid (C)	76 Mg.	2.5
Thiamin (B_1)	5.77 Mg.	5.7
Riboflavin (B_2)	8.6 Mg.	7
Niacinamide	16.8 Mg.	1.6
Iron	11.8 Mg.	1.1
Calcium	2.7 Gm.	3
Phosphorus	2.1 Gm.	2.8
Iodine	0.56 Mg.	5.6
Pyridoxine (B_6)	1.42 Mg.	**
Ca Pantothenate	11.8 Mg.	**
Vitamin B_{12}	2.0 Mcg.	**
Vitamin E	10.6 Units	**
Sodium	1.1 Gm.	**
Potassium	3.0 Gm.	**
Manganese	1.0 Mg.	**
Magnesium	1.3 Gm.	**
Copper	1.6 Mg.	**
Zinc	8.0 Mg.	**
Calories	1000	

**Calculations are based on a standard multi-vitamin-mineral supplement, 1½ cups Carnation Instant Nonfat Dry Milk, and 1 quart of whole milk.*

***M.D.R. (Minimum Daily Requirement) has not been established.*

Carnation Company

—*Continued from page 38*

tion had I been guided by your excellent articles on starting a practice.)

With that off my chest I'll get down to what I intended to comment on. I refer to the article, "A College Plan for Your Youngsters," in the December 1960 issue. The article was good, as far as it went. If you want to be able to send your children to college, you have to plan wisely and put your money into something (stocks, mutual funds) which will keep pace with inflation.

Still, if you have more than one or two children, the sledding will be rough. Today it costs about $10,000 to put your child through a Class A college. Multiply that by four (families are large these days) and you have $40,000. Add fees for a couple of kids who want to go to medical school, and . . . well, my arithmetic fails me.

It seems to me that it is almost impossible these days to fully provide for your children's higher education. What to do? I don't know. Part of the answer is part-time work for your college children. But that's a small part.

This may well be another area where the government may have to step in. Something along the lines of the G.I. Bill, perhaps, which made it possible for tens of thousands of ex-servicemen to complete college, a feat which most of them would not have accomplished without help. Maybe a broadened program of long-term government loans would help in this important area. I don't particularly like the idea but can see no practical alternative.

Are your readers too young to be considering this problem? I agree with your article: the time to consider it is *now!*

A. L. Hanson, M.D.
NEW YORK, N. Y.

Berry Plan

I wish to express my appreciation to RESIDENT PHYSICIAN for the many excellent articles you have provided for me during my residency. You are performing a most valuable service to medicine and to those of us in postgraduate training. I want to congratulate you on the thorough manner in which you cover the various subjects. So much of "popular" reading today is capsuled into the quick, superficial treatment of the subjects discussed. Perhaps that is because our world is moving so fast. But I for one enjoy the "in depth" quality of

—*Continued on page 50*

a **pair of postoperative patients:**

both are free of pain—but only one is on

DILAUDID®

(Dihydromorphinone HCl)

swift, sure analgesia normally unmarred by nausea and vomiting

Before and after surgery, DILAUDID provides unexcelled analgesia. Its high therapeutic ratio is commonly reflected by lack of nausea and vomiting — and marked freedom from other side-effects such as dizziness and somnolence. DILAUDID thus facilitates early ambulation and simplifies postoperative management.

by mouth **by needle** **by rectum**

2 mg., 3 mg., and 4 mg.

May be habit forming—usual precautions should be observed as with other opiate analgesics.

KNOLL PHARMACEUTICAL COMPANY • ORANGE, NEW JERSEY

—*Continued from page 46*

much of your content. Especially do I wish to thank you for the fine, comprehensive discussion of the Berry Plan ("A Look at the Berry Plan," RP December 1960). It was much more than just "a look," as you termed it. It was the most complete picture of the origin and development of this program I have ever seen in print. I shall be completing my residency in a few months but I wouldn't feel right if I didn't let you know how much I have enjoyed receiving your journal.

Walter J. Cooper, M.D.
BOSTON, MASS.

• *We wouldn't "feel right" unless we received letters such as yours. They give our entire staff a renewed incentive. Thank you for your interest.*

R. N. Agrees

Who is that amazing, wonderful doctor who can still find some humor in the sad state of professional nursing? (In the January issue of RESIDENT PHYSICIAN, "The Modern Nurse and Her Station" by Dr. Paul Hein, Jr.) For the last ten years, I have watched with a heavy heart while professional nursing had edu-

—*Concluded on page 54*

the nutritional approach to weight control

METRECAL™

BRAND

DIETARY FOR WEIGHT CONTROL

...clinical evidence continues to provide reassuring answers to pertinent questions

is Metrecal safe?

Metrecal has been used in a wide variety of medical disorders, including advanced stages of coronary and hypertensive heart disease, peptic ulcer, cirrhosis of the liver, diabetes mellitus and patients with extensive rheumatoid arthritis on steroid therapy. "No serious complications were observed."[1]

Metrecal contains no drugs. It "frees the physician and the patient from the undesirable crutch of the anorexigenic drugs, the metabolic stimulants, and the hydrophilic colloids."[1]

is Metrecal effective?

In long-term Metrecal studies of 101 patients, "...the average weight loss was 6.2 pounds in the first week, 4.5 pounds in the second week, 3.7 pounds in the third week and then 2.1 to 3.5 pounds per week from the fourth through the sixteenth week."[3]

In a 12-day study of Metrecal used as the sole source of calories, "the average weight loss for the 100 subjects was 6.5 pounds, or 3.9 per cent of the initial body weight."[2]

Available in powder and liquid forms in a variety of flavors

references: (1) Roberts, H. J.: Effective Long-Term Weight Reduction—Experiences with Metrecal, Am. J. Clin. Nutrition *8*:817-832 (Nov.-Dec.) 1960. (2) Antos, R. J.: The Use of a New Dietary Product (Metrecal) for Weight Reduction, Southwestern Med. *40*:695-697 (Nov.) 1959. (3) Tullis, I. F.; Allen, C. E., and Overman, R. R.: Simple Effective Weight Reduction: A Clinical Study, Scientific Exhibit, 6th Internat. Cong. Int. Med., Basel, Switzerland, Aug. 24-27, 1960.

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Edward Dalton Co.
A DIVISION OF
MEAD JOHNSON & COMPANY
EVANSVILLE 12, INDIANA

—*Concluded from page 50*

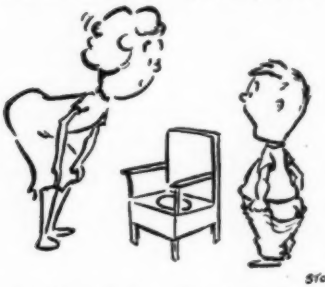
cated itself almost out of existence. Professional nursing is sick with "degree madness" which may be its own undoing. In her race to get away from the patient, the college educated nurse has almost worked herself into extinction.

This country cannot possibly use all the nurses who are getting degrees to teach, supervise and in short do anything but be nurses. It is obvious, almost to the point of being ridiculous, that what we need is more nurses to do nursing. Training more practical nurses and attendants is not the answer. They do the work, and nobly, but there must always be better educated, professional nurses to supervise them.

I wish that Dr. Hein's article could be reprinted in every medical and nursing magazine in the country. Even better still, we need a champion who can awaken nursing educators to what is ahead. We have on the one hand too many over-educated nurses who will not do bedside nursing and on the other hand lots of practical nurses and attendants who have to do the work, but need supervision. And right in the middle, we find a very bewildered, neglected person, THE PATIENT.

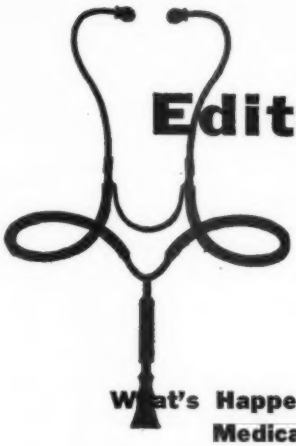
A possible solution might be to abolish or change some of the present day four or five year college programs and go back to the "old fashioned" three year programs. At least in the three year programs, we would get some nursing care out of the student nurses and that would help alleviate some of the shortage. I realize that this is all heresy, though.

An R.N.
(Name withheld at writer's request)
DENVER, COLORADO



"Can I have the dime again when we find it?"

Perrin H. Long, M.D.



Editor's Page

What's Happening to Prospective Medical Students?

We have heard a great deal lately about the decline in applicants for medical schools in this country. It has been stated that with the decline in the number of applications, the academic and intellectual quality of the applicants has also declined over the years. In the next breath we are told that by 1970 we will need X number of doctors, and by 2000, X + Y doctors. Then, figurative arms are raised to the high heavens, and with the voices of a Jeremiah, prophets true or false (who knows which?) proclaim that an increasing shortage of medical school spaces is rapidly developing, and they cry out for the financing and construction of from ten to twenty new medical schools in the next few years.

It is estimated that it costs $600,000 per anticipated student to finance properly a new medical school today. If true, this should disturb all of us and we should estimate accurately just what the situation is and then determine soberly and without emotion (eliminating those academic and medical empire builders and administrators whose mouths frequently water for the juicy morsels they see looming in the future), what we must do to provide

adequate medical care and research for our people. I say our people, because they should be our overriding consideration. After all, they are going to foot the bill one way or the other.

First, let us consider what's happening in respect to the "number of applicants" who are applying for admission to medical schools in this country. During the years 1947-48 to 1951-52 (a five-year period), applicants averaged roughly twenty thousand per year, and an average intake of seven thousand per annum was recorded by the medical schools.[1] This large group of applicants represented the bulge produced by World War II veterans, whose education was financed largely by the G.I. Bill of Rights, plus the normal yearly influx of non-veteran applicants.

In the five years ending 1959-60, applicants averaged fifteen thousand per year, while those accepted for medical school averaged slightly over eight thousand per annum during that period. These figures do not include those American citizens who, rejected for medical school at home, applied and were accepted by medical schools outside the United States and Canada. These are said currently to number about one thousand per annum. To sum up, it would appear likely that we have had five thousand less applicants for medical school per year in the last five years, while registering an input into American medical schools of more than one thousand per annum over that noted per year from 1947-48 to 1951-52. *There were few applicants but more were accepted.* Americans studying medicine abroad would swell this figure appreciably.

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1. Datagram, Association of American Medical Colleges, Vol. 2, No. 4, October, 1960.

We hear from many that the intellectual quality of the students accepted has declined along with the number of applicants. Let's take a look at that. If one studies the results of the Medical College Aptitude Tests given to applicants from 1955-56 until 1959-60, one notes very little variation in the group of mean scores for those accepted and for those who were not accepted.[2] On the basis of these MCAT scores, one would be forced to say that the quality of those *accepted* varied little during that eight-year period.

The question may be raised: "How valuable are MCAT scores in assessing the intellectual superiority of the mass of acceptable candidates?"[1] It seems to us that the honest answer is, "We are not sure; we wish we could be." There is one puzzling aspect of these scores over the past eight years. While there has not been much change in MCAT scores of successful applicants (or for that matter, of unsuccessful applicants), the number of students in first year medical classes *who had an "A" record in college has definitely decreased.* From what one can gather, despite the MCAT figures, most medical educators seem to believe that the intellectual quality of applicants has declined over the past several years.

The next question is: "If it is correct that the intellectual attributes of entering students has declined, why has it happened and can anything be done about it?" By hearsay and gossip, one may postulate that the very exciting and initially certainly more remunerative areas in physics and chemistry have attracted bright young men and women who otherwise would have gone into medicine. This is understandable and it seems reasonable to

2. Datagram, Association of American Medical Colleges, Vol. 2, No. 5, November, 1960.

believe this is true. Secondly, in the last ten years the immediate financial returns of a college education have increased. Two years ago, all graduates of a well-known small liberal arts college had jobs by August first of the year of graduation, with B.A. graduates averaging $4800 and those with a B.S., $5200 the first year out of college. Also, these youngsters believed they would double their salaries in ten years. Contrast this attraction with the fact that the medical student will be paying out about a thousand dollars a year for tuition alone in the four years after he has graduated from college, and as an intern and resident for from one to six years, will rarely reach the first year income of the B.S. graduate. He is seven to ten years behind, financially speaking.

Furthermore, in this day and age, whether one approves of it or not, marriages are taking place at a much younger age. For a young married couple, the thought of another seven to ten years of education and training must look pretty grim and, of course, children complicate their outlook.

Finally, whether one likes it or not, we are getting into an era in which higher and professional educations *are coming to be considered a right and not a privilege to all who wish to have such an education, and that someone other than the individual should pay the costs of education.* This we have increasingly noted in interviews with applicants for medical school. Unfortunately private scholarship funds have not grown apace with the demand for them, and with the marked decrease in individuals eligible for the G.I. benefits, the succeeding National Defense Education Act of 1958 does not fill the bill because money received under it is in the form of a *loan* and not a *gift*. It also requires an outlay on the part of the medical school involved, which in most instances cannot be met.

To cope with this situation, it would appear that before

long we will have to resort to Federal funds for supporting directly the education of medical students, and as it is axiomatic that in the long run "he who pays the piper calls the tune," our voluntary medical schools will come more and more under the domination of the Department of Health, Education and Welfare. But as our medical schools are becoming year by year more dependent on funds from the Federal Government, the transition to governmental financial control of medical education, which is bound to come, will probably not disturb many medical educators.

Perrin H. Long.

"It looks bullish, T. P."

CANIGLIA

RESIDENT PHYSICIAN SPECIAL SURVEY REPORT

What You Told Us...

How many patients do you handle in an average day in the outpatient clinic?

How much authority do you have in outpatient management?

How many prescriptions do you write?

These were some of the questions asked in the recent RESIDENT PHYSICIAN survey conducted among residents and interns in A.M.A. approved programs. Here you can check your own experience against the results of the poll. You may find some surprises.

Our survey statistics show that more than 85% of all house officers attend outpatient clinics. (Since our poll was conducted among residents in both the clinical and nonclinical specialties, it can be assumed that virtually all house officers in the clinical fields attend outpatient clinics.)

Time spent on outpatient service is at the rate of 3 days a week, 38 weeks a year. Number of patients seen in a clinic day averaged slightly more than 13. The resident, figures show, spends more time in the clinics than does the average intern (Table 1).

Management

The number of patients and the time spent in clinics are two important yardsticks in measuring the experience offered in a training program. The survey results reflect still another aspect of this experience:

. . . *about clinics, Rx's, brand vs generic names, pharmaceutical advertising and cost of drugs*

• 75% of interns and residents in outpatient clinics are supervised by attendings.

• 65% of all respondents stated they had "practically complete authority" in patient management. (About 9% more residents than interns felt they had "practically complete authority" in management.)

• More than 95% of all house officers attending clinics said they had "practically complete" or "a great deal" of authority in outpatient management.

That the outpatient clinic is a vital training area for decision-making by the individual house officer is firmly supported by this survey.

Interns in outpatient clinics write an average of 16 prescriptions a day, and residents 12.5 a day. Together, house staff members averaged 13.6 prescriptions per clinic day, according to our survey.

Cost

Though they write a substantial number of prescriptions, barely 41% of the house officers felt they had a *"good"* or *"excellent"* knowledge of the cost of the drugs they prescribe (Table 2). Over 20% felt they had a *"poor"* or *"very poor"* idea of drug costs. In this regard, the greater experience of the residents was reflected: 47.5% of residents thought they had a good

TABLE 1 FREQUENCY OF ATTENDANCE

	INTERNS	RESIDENTS	TOTAL HOUSE STAFF
Average number of **weeks** per year spent in attending outpatient clinics	31.72	41.03	38.06
Average number of **days** per average week spent in attending outpatient clinics	2.08	3.31	2.91
Average number of **clinic patients** seen in average clinic day	11.14	14.43	13.42

or excellent knowledge in this area as against 27.3% of interns.

These results seem to indicate the absence in most training programs of formal orientation on the cost of drugs. Yet, both the "hospital practice" and private practice of medicine, in the opinion of virtually all medical educators and practitioners, demands at least a working knowledge in this area.

Prices

To further examine the economic aspect of drugs and prescriptions, we asked the following question: *"Do you feel that prices on RX pharmaceuticals in general are: about right, too high, too low?"*

Almost three-fourths of all house officers who write prescriptions indicated that they thought Rx drug prices were too high. Here interns and residents were almost in complete agreement: 74.4% of interns and 73.1% of residents stated that prescriptions are overpriced. About 25% of each group indicated prices to be "about right" and 0.7% felt the prices to be "too low." Since answers to this question appear to contradict, to a degree, the "knowledge of drug costs" expressed in Table 2, it is probably fair to term the response here as an expression or measure of "attitude." Since the survey was conducted during the highly-publicized Kefauver Committee hearings, it is probable that this fact was reflected in the response. Yet, this fact may well indicate that although the drug-makers have a positive story to tell re prices, they are either not telling it often enough or convincingly enough to house staff doctors.*

The following two questions were closely linked. They both examined attitudes about the importance of manufacturers' names

TABLE 2 KNOWLEDGE OF DRUG COSTS

	INTERNS	RESIDENTS	TOTAL HOUSE STAFF
Have an excellent idea of drug costs	6.4%	12.2%	10.3%
Have a good idea of the drug costs	20.9	35.3	30.8
Have a fair idea of the drug costs	45.0	35.8	38.7
Have a poor idea of the drug costs	24.5	13.3	16.8
Have a very poor idea of drug costs	3.2	3.4	3.4

TABLE 3 PRESCRIBING BY GENERIC NAMES

	INTERNS	RESIDENTS	TOTAL HOUSE STAFF
Would have confidence in prescribing Pharmaceuticals by Generic Names	80.2%=100%	79.6%=100%	79.8%=100%
Manufacturer of Pharmaceuticals			
Important	17.8%	21.2%	20.1%
Unimportant	82.2	78.2	79.4
Don't know	—	0.6	0.5

TABLE 4 CONFIDENCE IN PRESCRIBING BY MANUFACTURER

	INTERNS	RESIDENTS	TOTAL HOUSE STAFF
Would have more confidence in prescribing product of:			
Well-known pharmaceutical manufacturer	42.3%	46.4%	45.1%
Lesser-known pharmaceutical manufacturer	1.8	0.9	1.2
Either type of manufacturer	55.9	52.7	53.7

TABLE 5 SOURCES OF NEW DRUG INFORMATION

	INTERNS	RESIDENTS	TOTAL HOUSE STAFF
Considered Valuable			
Journals	68.6%	72.2%	71.0%
Detail Men	45.4	49.7	48.4
Drug Company	38.7	36.2	37.1
Other MDs	36.5	32.8	34.0

in judging the quality of pharmaceuticals (Tables 3 and 4). Of all interns and residents surveyed, nearly 80% said they had confidence in prescribing by generic names. Of the latter group, four out of five felt that knowledge of the manufacturer of a particular drug was "unimportant."

Yet, in reply to another question which implied a choice solely among brand names—with no option for a generic choice—45% said they would have more confidence in prescribing the product of a well-known manufacturer than in the product of a lesser-known manufacturer. More than half of all respondents stated that they would have confidence in either type of manufacturer.

Finally, respondents were asked to list, in order of value, sources of information considered value in regard to new drugs (Table 5). The four most important, in order, were: journals (by a wide margin), detail men, drug company literature and other doctors.

OUR QUESTIONNAIRE, consisting of 160 questions, was sent to nearly 4,000 residents and interns.

More than 33% of the questionnaires were completed and returned. We sincerely appreciate your cooperation! ED.

Because of the length of the questionnaire, we found it impossible to do justice to the final figures in a single article. The first report appeared in a previous issue of your journal, and this is the second.

Two points might be mention here: First, no list was given. Respondent had to make his determination without "prompting." Secondly, the longer the period of training already completed by the respondent, the more reliance he placed in journals and detail men.

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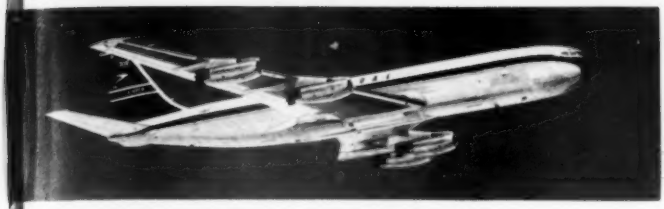
* Drug-makers do have a positive story. If the reader will take the initiative by writing to the Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C., information will be provided.



GRAND PRIZE—14 days in Europe for two, with deluxe accommodations. Begins with British Overseas Airway's 707 Intercontinental jet to London, includes visits with foremost internists in England and European centers.

SECOND GRAND PRIZE—Safe, economical, efficient transportation are among the important performance features of the 1961 Triumph/Herald. An outstanding automobile, holder of international awards for engineering design.

THIRD GRAND PRIZE—$1,000—one big check for dreams, or bills, or groceries, or entertainment, or travel or . . . Sig. p.r.n.

The WINNERS.....

It couldn't have been closer!

RESIDENT PHYSICIAN CONTEST WINNERS

Two Overtime Matches Needed

THE TRIP · · ·

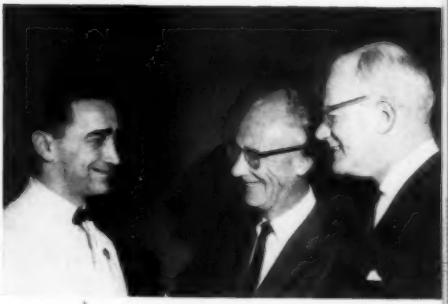
THE CAR · · ·

In a stretch battle which swept through a pair of overtime contests, two house officers at the same hospital were named the First and Second Grand Prize winners in the RESIDENT PHYSICIAN nationwide, $10,000 Mediquiz—"It Pays to Read . . ." Contest. One was a resident, the other an intern.

The top prize, an all expenses paid, 14-day European trip for two by BOAC-707 jet, with deluxe accommodations and conducted tours of outstanding medical facilities in England and the continent, was won by John R. Baringer, 25, a first year resident in medicine at Massachusetts General Hospital, Boston.

Stanley H. Appel, 27, a rotating intern at Massachusetts General, was the winner of the Second Grand Prize, a British Triumph/Herald sedan.

◀ Congratulations are in order as Dr. Perrin H. Long, *Resident Physician* Editor-in-Chief, compliments Resident John Baringer on his winning effort.



▶ Winner of the Second Grand Prize, Intern Stanley Appel, receives the congratulations of Dr. Dean A. Clark, General Director, Massachusetts General Hospital and W. Randolph Morando (center), the publisher of *Resident Physician*.

JOHN RICHARD BARINGER

Ohio State, B.S., 1955; Western Reserve, M.D., 1959, now in his first year of residency in medicine at Massachusetts General Hospital, Boston. Born in Columbus, Ohio, and a graduate of Columbus North High School, he now calls Reynoldsburg, a suburb of Columbus, his home. Married, with a year-old son, his future plans are for a neurology residency at MGH and eventually research in the field. Published paper: "The Dynamic Anatomy of the Microcirculation in the Amphibian and Mammalian Kidney."

STANLEY H. APPEL

Harvard College, A.B., 1954; Columbia College of Physicians and Surgeons, M.D., 1960, an intern in medicine at Massachusetts General Hospital, Boston. Born in Boston, he attended Boston Latin High School. He is married and has a three-year-old son. He plans to continue with a residency in internal medicine and neurology. Clinical and research work in neurology is his goal. Published paper: Tranquilizing Drugs — An Approach to the Biochemistry of Mental Disease, *New Engl. Ctr. Bull.*, 1:58.

"IT PAYS TO READ . . ."

After carding perfect scores through five months and 100 questions, the two then completed 50 special questions, beating out five other house officers who had also posted perfect scores in the regular contest. Still locked in a tie with each other, they struggled through a second set of 50 tie-breaking questions before the final winner could be named.

$1,000 ... $5

The other five residents with 100% scores in the regular contest, fought it out for the next highest prizes, including the Third Grand Prize of $1,000 which was won by William L. Underhill, 28, University Hospital of Cleveland.

The Fourth Prize of $500 was won by Francisco M. Gonzalez, a resident at District of Columbia General Hospital, and the Fifth Prize of $250 was awarded to Peter H. Schur, second year resident at Bronx Municipal Hospital, New York.

In all, 132 prizes were awarded to residents and interns in 30 states. Originally listing only 120 prizes, the publishers of RESIDENT PHYSICIAN expanded the number to include duplicate prizes for those who tied for the $25 awards, rather than eliminate twelve of them in a runoff contest. From the top prize to the last prize, the spread of incorrect answers was extremely narrow; every winner scored 96% or better in the regular contest.

THIRD PRIZE—$1,000

WILLIAM LEE UNDERHILL, Colgate University, A. B., 1954; University of Rochester, M.D., 1958, now in his second year of internal medicine at University Hospitals of Cleveland. Born and raised the son of a GP in Erie, Pa., he is 28, married and has a daughter 3, a son 1½ years old. Recipient of the War Memorial and Austin Colgate Scholarships and a Phi Beta Kappa while in college, his major scientific interest is in cardiovascular disease. He intends to enter private practice in internal medicine after completing his residency.

... $500 ... $250 ...

OURTH PRIZE—$500

ANCISCO M. GONZALEZ, 27, Virginia Military Insti-e, A.B., 1953; Medical College of Virginia, M.D., 1957, ef (third year) medical resident, Georgetown Medical ision, District of Columbia General Hospital. Born San Juan, Puerto Rico, he is married, has one child. r internship at Georgetown University Hospital, he successive residency years in medicine at Charity spital of Louisiana and Georgetown University Hos-al, Washington, D. C. He plans to take a fellowship, ntually entering academic medicine.

FIFTH PRIZE—$250

PETER H. SCHUR, 27, Yale University, B.S., 1955; Harvard Medical School, M.D., 1958, in second year medicine at Bronx Municipal Hospital Center, New York. The son of physician parents, he was born in Vienna, Austria, attended Fieldston School in Riverdale, New York. A lieutenant in the USAR (MC), he will become chief resident in medicine at Bronx Municipal Hospital in July. In addition to research in immunoelectrophoresis, he is completing a paper on Waldenstrom's Macroglobulinemia. Academic medicine with a part-time practice is his goal.

ician

. . . and 6 at $100

6

YOLANDA MAPP, 30, Monmouth Jr. Coll., Assoc. A, 1951; Douglas Coll., Rutgers University Women's College, B.S., 1953; Howard University Medical School, M.D., 1957, in third year residency in medicine at District of Columbia General Hospital. Born in New York City, her home is in Red Bank, New Jersey. She is married to Navy physician Esmond Mapp (Howard University, M.D., 1958) who will enter a pathology residency this year at University of Pennsylvania Graduate Hospital, Philadelphia. They have four sons. Dr. Yolanda Mapp was a Schering Honor Award winner in 1957 for her paper: Incidence of Cardiovascular Disease in Males and Females According to Age.

7

RITCHARD L. FISHMAN, 29, Ohio State University, A.B., 1953, and M.D., 1957, now first year resident in pediatrics at Queen of Angels Hospital, Los Angeles, following internship at Charity Hospital of New Orleans, and surgical residency at Alton Ochsner Hospital and U.C.L.A. Medical Center. Born in New York City, with early education in Dayton, O., he plans a private pediatric practice.

8

KENNETH COHEN, 31, Drake University, B.A., 1951; University of Illinois Medical School, M.D., 1955, now in his third year of residency in medicine at Cook County Hospital. Married, with two daughters, he served two years as a physician in the USAF (MC). He was born in Chicago and makes his home in Wilmette, Ill. Co-author of paper, Vitamin K and Hypoprothrombinemia of Liver Disease, **Geriatrics,** 10:60, he hopes to enter private practice in the Chicago area upon completion of residency this year.

9

GERHARD HAASE, 31, Northwestern, B.S., 1951; University of Illinois Medical School, M.D., 1955. Interned at Cook County Hospital and is now a third year resident in medicine at Cook County. A Phi Beta Kappa, he served in England in the USAF (MC) for two years, and his future plans include private practice. Born in Berlin, he attended Lake View High School in Chicago where he presently makes his home.

BRYANT I. PICKERING, 31, University of Minnesota, B.A., 1955, and M.D., 1958, now second year resident in internal medicine at Mayo Clinic. Born in Ekalaka, Mont., he had his early education in Albert Lea, Minn., and lists his home town as Geneva, Minn. From 1947 to 1950 he served in the U.S. Navy Hospital Corps, engaging in radiobiological research. He is married, with a son and daughter (a third child is expected next month). In medical school Dr. Pickering won two scholarships and the Ski-U-Mah Leadership Award (U. of Minn., 1958). Future plans call for private practice in a small group.

10

11

LESLIE J. SCHOENFIELD, 29, Temple University, B.A., 1952; Temple University Medical School, M.D., 1956, now second year resident in medicine at Mayo Clinic. Married, with two sons (third child expected this month), he interned at Temple University Hospital and served two years in the Army (MC) as ward physician at an Army hospital. Born in the Bronx, New York, he lists his home town as Philadelphia where he attended Central H.S. He was editor of his medical school yearbook and has authored two papers on bilirubin metabolism. His future plans include a Ph.D. and subspecialty study in gastroenterology.

Team Effort Makes for Tight Race

There were a number of aspects of the Mediquiz Contest that made it unusual, other than the fact that it was the first nation-wide contest of this type ever conducted exclusively among residents and interns. First, there was the encouragement of journal reading through the theme of the contest; "It Pays to Read Current Medical Journals." Of the nearly 50 journals used as source material for questions, all were on the AMA recommended list for teaching hospital libraries. From letters received from contestants as well as many from hospital librarians, it is reasonable to assume some house officers made their first acquaintance with certain journals—especially those outside their own specialty —and also renewed lapsed friendships with journals with which they had previously been on close terms.

A second aspect of the Contest was the encouragement of "team" participation. Recognizing that the time of house officers is utilized to a maximum degree in patient care, teaching and research assignments — not to mention

sleep and time spent with their families—it was felt that the fairest means of allowing for variation in available time among individual house staffers, would be to allow joint effort in handling the monthly Contest questions. The editors of RESIDENT PHYSICIAN also felt that this would encourage cooperation between residents of the different specialties—the kind of cooperation which is a vital element of American medical practice.

The number of hospitals having multiple winners indicates the success of the "team" method employed in the Contest.

When it came to the ties—and the need for breaking the ties—it would have been considerably easier to end the "open book" method of questioning and move to a supervised "closed book" examination among tying contestants. This would have automatically ended the team effort, of course. But this was discarded since it would be a fundamental departure from the purpose and nature of the Contest by eliminating the basic ingredient, i.e., open reference to medical journals.

Thus, a system for giving virtually simultaneous tie-breaking examinations in various centers was worked out (see page 80), and a time limit was imposed.

Contest Sidelights

The two top winners, faced with time limitations involved in the two tie-breaking Contests, were given some welcome assistance. To permit them to utilize the library when they had free time at night, they were given a key to the library. Both agreed this was an important factor in their victory.

• • •

The Third Prize winner faced a dilemma, too. Since the tie-breaking questions were taken in part from medical journals of the preceding six months period, he was stunned when he found his library had sent earlier issues to the binders. "Fortunately, the General Bookbinding Company of Cleveland was located only a few blocks from my hospital," he reported. "Through the courtesy of Mr. Powers of that company, I was able to load up my car with the journals and keep them for a few days . . ."

While thanking Mr. Powers, we would like to extend our appreciation on behalf of all contestants, to the hundreds of medical librarians throughout the U.S. who went out of their way to cooperate.

. . . and 9 at $50

LEWIS BURROWS, 30, second year surgery resident, Mount Sinai Hospital, New York City. Graduate, New York University and NYU-Bellevue Medical School ('56).

ROBERT E. DAHMS, 30, fourth year urology resident, Harbor General Hospital, Torrance, California, and a graduate of De Pauw and the Stritch School of Medicine ('56).

JOHN T. DIFFERDING, 27, first year pathology resident, San Francisco General Hospital. Born and educated in California, he graduated from Stanford and Stanford Medical School ('59).

RICHARD C. EVANS, 28, second year psychiatry resident, Bronx Municipal Hospital, New York. Graduate, Columbia College and Cornell Medical School ('58).

DAVID W. FOERSTER, 27, second year surgery resident at University Hospital, Oklahoma City his hometown. A graduate of Yale and the University of Oklahoma Medical School ('58).

GEORGE B. NAFF, 29, third year medicine resident, University Hospital of Cleveland. Graduate, Roanoke College and University of Virginia ('57).

HEINRICH SCHMID, 34, second year pathology resident, Queens Hospital, Honolulu. Born and educated in Germany, he attended medical school in Hamburg and Heidelburg.

CAMERON G. STRONG, 26, second year medicine (pathology), Queens Hospital, Honolulu. Born in Canada he graduated from the University of Alberta, Faculty of Medicine, in 1958.

LELAND G. TAYLOR, 27, first year pathology resident at San Francisco General Hospital. Graduate, Stanford ('55) and Harvard Medical School ('59).

"IT PAYS TO READ . . ."

. . . and 112 at $25

ALABAMA

SHUTTLEWORTH, JOHN G., Lloyd Noland Hospital, Fairfield

CALIFORNIA

BAUER, JAMES E., Memorial of Long Beach, Long Beach
CONRY, KENNETH F., Queen of Angels, Los Angeles
DARRAS, ROBERT L., Memorial of Long Beach, Long Beach
ESCAJEDA, RICHARD M., U. S. Naval Hospital, San Diego
FUKUMOTO, RICHARD I., Memorial of Long Beach, Long Beach
GOIN, JOHN M., UCLA Medical Center, Los Angeles
GOIN, MARCIA K., Los Angeles County General, Los Angeles
GRAY, JAMES V., Highland-Alameda County, Oakland
GRIFFIN, WILLIAM V. III, Memorial of Long Beach, Long Beach
JENKINS, CHARLES E., Memorial of Long Beach
JONES, MILTON R., Memorial of Long Beach
KASPER, CAROL K., St. Mary's, San Francisco
LYNCH, THOMAS J., Memorial of Long Beach, Long Beach
MCKAY, BARRY J., Memorial of Long Beach
MORGAN, WILLIAM A., Palo Alto-Stanford Center, Palo Alto
MOSKOWITZ, JOSEPH, Memorial of Long Beach, Long Beach
NATTER, CARL E., Memorial of Long Beach
NATTER, JEAN R., Memorial of Long Beach

The "Winningest Combine"

One out of every five prize winners from California

IN LINE FOR PRIZES.....

California residents and interns outraced those of all other states and territories in the nationwide $10,000 Mediquiz Contest of your journal. Placing 28 in the winner's list of 132 residents and interns, California house staffers topped the next best total of 14 winners from New York and 13 from Ohio. Among the California winners, 14 were house staff members at Memorial Hospital of Long Beach, ranking that hospital first in the nation in number of prize winners. Mayo Clinic with six award winners and Akron General with five were the next in number of winning contestants. University Hospital

PAYS
READ . . ."

NAYLOR, JACK, Santa Barbara Cottage, Santa Barbara
RAMKISSOON, REUBEN A., Memorial of Long Beach, Long Beach
SMITH, JAY R. V., Memorial of Long Beach
STAHELI, HARVEY K., Highland-Alameda County, Oakland
STANSIFER, PHILIP D., Letterman Army, San Francisco
WEILAND, RONALD T., Memorial of Long Beach, Long Beach

COLORADO

CARLIN, ALLAN W., Colorado General, Denver
DEL CASTILLO, JUAN J., Colorado State, Pueblo
KINCAID, JOSEPH E., Colorado General, Denver
RODRIGUEZ, FRANCISCO J., Colorado State, Peublo
RODRIGUEZ, LUIS R., St. Mary Corwin, Pueblo
WILSON, HOWARD E., Saint Luke's, Denver

CONNECTICUT

LICHTENSTEIN, NORMAN S., Grace-New Haven, New Haven
WINSTON, HERBERT, Yale Psychiatric, New Haven

DISTRICT OF COLUMBIA

DELLER, JOHN J., Walter Reed General, Washington

FLORIDA

SACK, JOSUA, Veterans Administration, Coral Gables

GEORGIA

MANN, THOMAS C., Eugene Talmadge Memorial, Augusta

ILLINOIS

COMINGS, DAVID E., Cook County, Chicago
TATAR, ARNOLD M., Michael Reese, Chicago
URNES, PAUL D., Passavant Memorial, Chicago
VALADKA, BRONIUS, Veterans Administration, Hines

.....Long Beach Memorial Hospital's award-winning team.

(Cleveland) with four awards saw two of its four winners place among the "top twenty." D. C. General and Cook County hospital each had two winners among the first ten.

In all, eight hospitals tied for top honors, each having two house officers listed in the first twenty prize awards. These hospitals include Massachusetts General (with the first and second prize winners) Bronx Municipal Hospital, University Hospital of Cleveland, Cook County, Mayo Clinic, D. C. General, San Francisco General and Queens Hospital, Honolulu, Hawaii.

INDIANA	FOREMAN, THOMAS M., Indiana University Center, Indianapolis LAVY, NORMAN W., Indiana University Center
KANSAS	PERRY, CARLOS J. G., Veterans Administration, Topeka PROKOP, BRADFORD S., Kansas University Center, Kansas City
LOUISIANA	LEON-SOTOMAYOR, LUIS A., Charity of Louisiana, New Orleans
MARYLAND	BAUMGARDNER, GEORGE R., University Hospital, Baltimore LEVIN, RICHARD L., University Hospital OURSLER, DAVID A., University Hospital
MASSACHUSETTS	BERRY, YALE J., Beth Israel, Boston BONAME, JOHN R., U. S. Naval Hospital, Chelsea FIALA, MILAN, Newton-Wellesley, Newton Lower Falls

A Problem in Logistics:

How the Ties Were Broken

Anticipating ties at the close of the five month Mediquiz Contest, two separate sets of 50 questions were prepared. After tabulating the answers to the final contest month (December), seven house officers had correctly answered all 100 regular contest questions, and were tied for the grand prize. Thirteen physicians were grouped together in the second slot, each having missed but one question during the five month competition. Because of these ties, all 20 physicians were notified by telegram that they would receive in a few days a set of tie-breaking questions. Contestants were not told which prize they were tied for.

In order to control the delivery and return of these questions, a special arrangement with Western Union was worked out to permit the New York office to send the questions to the Western Union branch offices in each of the cities in which a tied contestant was located: New York, Boston, Washington, D. C., Rochester, Minn., Chicago, Oklahoma City, Torrance, Calif., San Francisco and Cleveland. (Western Union doesn't have an office in Honolulu, so the two tied residents in that city received their questions via registered mail.)

Each W. U. local office then

LITWIN, MARTIN S., Peter Bent Brigham, Boston
LITWIN, SONNY B., Massachusetts General, Boston
PARENTEAU, ROGER E., Carney, Dorchester
PENALVA, HERNAN J., Newton-Wellesley, Newton Lower Falls
SHOHET, STEPHEN B., Beth Israel, Boston

MICHIGAN

CLARKE, HALDANE D., Henry Ford, Detroit
KAUFMAN, JACK H., Wayne County General, Eloise
POTTER, GUY D., Blodgett Memorial, Grand Rapids

MINNESOTA

ALLEN, JAMES R., St. Mary's, Minneapolis
BRUNSTING, CARL D., Mayo Clinic, Rochester
GARB, ALLAN E., Mayo Clinic
KINNEY, VENARD R., Mayo Clinic
WILLIAMS, DAVID E., Mayo Clinic

telephoned the hospital to arrange with the contestant when he would be free to receive the questions. A messenger was then sent to the hospital with instructions to deliver the envelope only to the addressee and receive a signed receipt. RESIDENT PHYSICIAN was notified of the time and day of delivery and sent the receipts signed by the addressees. The contestants also completed a receipt form, mailing it to RESIDENT PHYSICIAN.

The tied contestants were allowed 72 hours to answer and mail the questions, informing RESIDENT PHYSICIAN of the time and day mailed. Ten days after the start of this tie-breaking operation, all answers had been received, an achievement of note since one contestant was in the process of switching hospital assignments, another was almost 1,000 miles from where he was thought to be, and the Middle West and East were ravaged by two severe snowstorms which slowed normal mail service.

Although the 50 extra questions separated contestants, a pair of ties still remained: two physicians were tied for first prize and three others, for the third prize. A second set of 50 questions was then dispatched utilizing the same procedures as before. However, those tied were given only 24 hours to complete the questions. This resolved the ties and winners were notified.

MISSOURI	BOYCE, JOHN M., St. Luke's, St. Louis HEADRICK, JOHN A., St. Luke's MULLINS, JOHN E., St. Luke's STROUD, ROBERT M., Barnes, St. Louis
NEBRASKA	KEUTER, WILEM, St. Elizabeth, Lincoln RESKALLAH, TOTMES T., St. Elizabeth
NEW HAMPSHIRE	CLARENDON, COLIN C. D., Mary Hitchcock, Hanover
NEW YORK	BENNETT, DALE E., Strong Memorial, Rochester BROWNE, EUGENE A., Veterans Administration, New York City DOAN, ALLEN E., Strong Memorial, Rochester ECHIKSON, ALAN B., Mount Sinai, New York City FRIEDMAN, GERALD, Mount Sinai GHOSSEIN, NEMETALLAH A., Francis Delafield, New York City GINSBERG, DONALD M., Beth El, Brooklyn JOMAIN, SERGE L., Kings County, Brooklyn ROSENBERG, LAWRENCE C., Bronx Municipal, Bronx SILON, NATHANIEL, Meadowbrook, East Meadow WELCH, ETHAN L., Bellevue, New York City
NORTH CAROLINA	SELLERS, PHILLIP A., North Carolina Baptist, Winston-Salem
OKLAHOMA	KEY, CHARLES R., University of Oklahoma, Oklahoma City STEPHENSON, JACK M., University of Oklahoma TROYER, WILLIAM G., University of Oklahoma
PENNSYLVANIA	BREHM, HANS H., Geisinger Memorial, Danville CEREMSAK, ROBERT J., Geisinger Memorial HEINEMAN, HERBERT S., Presbyterian, Pittsburgh PALMER, TREVELYAN E., Presbyterian, Philadelphia ZUG, CHARLES K., Pennsylvania, Philadelphia
OHIO	CARLSTON, JOHN A., Akron General, Akron FINLEY, ROBERT H., Akron General JACKSON, THOMAS W., Bethesda Hospital, Cincinnati KELLUM, ROBERT E., Cleveland Clinic, Cleveland KETTELKAMP, RALPH A., Akron General, Akron RALPH, JAMES R., Akron General RILEY, THOMAS R., Akron City, Akron SHEPARDSON, CHARLES R., University Hospital, Cleveland SINCLAIR, WILLIAM P., Akron General, Akron TANNEHILL, ROBERT B., Children's, Akron WILLIAMS, JAMES S., University Hospital, Cleveland

TEXAS	FALCONER, HUGH S., Scott & White Memorial, Temple GONZALEZ, AMADOR, Jefferson Davis, Houston MCGUIRE, PHILIP R., Parkland Memorial, Dallas REYES, HUGO A., St. Joseph, Houston
VIRGINIA	HANSEL, JOHN S. JR., University of Virginia, Charlottesville MCLEAN, WILLIAM D., University of Virginia
VERMONT	DOS, SERGE J., Mary Fletcher, Burlington
WISCONSIN	LANG, GORDON E., Madison General, Madison LANG, JEAN L., Madison General ROSANDICH, RONALD J., Ladd Memorial, Osceola

Contest Sidelights

The winning combine from Long Beach reported they had used a system based on "division of labor," each resident being assigned 10 journals each month. At one point, when faced with a particularly baffling question, they pooled funds to send three telegrams (total cost, $9) to a trio of "top men in the field." Result? "Three different answers!" No further telegrams were sent.

• • •

Double congratulations are due prize winner Yolanda Mapp of District of Columbia General Hospital.

Throughout the contest, Resident Mapp, wife of Navy doctor Esmond Mapp, was expecting more than just a contest prize. On maternity leave from her residency, she was worried about the tie-breaking questions. "Would they come before the baby—or during?" she wondered. Fortunately, the questions arrived and were answered before the appearance of baby Daniel Mapp on February 10, 1961. Incidentally, Daniel is the fourth child and fourth son, having been preceded by Donald, 5, David, 4, and Douglas, 2. Mom and boys doing fine, thank you.

• • •

Prior to the contest, a special letter was sent to all teaching hospital librarians in the U.S. by Resident Physician, alerting them to the contest and asking them to hold up binding their journals wherever possible until the contest was completed. Some, having contract commitments with the binders — and no shelf space to hold the journals — were unable to accede to this request. But our thanks to the many librarians who managed to solve this problem.

A **Resident Physician** MONTHLY FEATURE

Clinical Pathological Conference

The Lankenau Hospital, Philadelphia

A 57-year-old woman of Finnish extraction was admitted for the first time in December, 1941 for sudden severe pain over the left lower abdominal and suprapubic areas which radiated out into the flank and down the left leg. She had noted a burning sensation but some diminution of the pain on micturition. In 1913 in Finland, "a stone from the left kidney and a small tumor" were removed. She had been asymptomatic since this operation.

Past history revealed "toxic thyroid" removed in 1932; surgical menopause in 1932 following operation for removal of "tumor of the womb;" asthma and "sinus trouble" for the past five years with a severe attack of dyspnea occurring one week prior to admission. Patient had had two normal full term pregnancies.

Admission physical revealed BP 120/80, P. 100, T. 99°, and weight 97 lbs. Patient appeared underdeveloped and undernourished. There was a mucopurulent discharge on a nasal turbinate; healed thyroidectomy scar; audible wheezes throughout both lung

fields; healed paramedial abdominal incision; tenderness on percussion over both costovertebral angles, being more pronounced on the right.

Laboratory

Urinalysis: Sp. gr. 1.017 with many RBC microscopically. Hb. 12 gm; RBC 4 M; WBC 14,900 with P-75%, L-18% and E-7%; BUN 8.8 mg%.

Flat plate of the abdomen revealed "clusters of calcareous material in both renal pelvic areas." EKG was interpreted as a normal tracing. Course in the hospital was uneventful after the pain disappeared. The urologist recommended conservative treatment and after 18 days the patient was discharged.

Readmissions

From the first admission to her death in 1954, the patient had 21 readmissions. An abstract of the pertinent findings follows.

1. (1-31-42) CC: "Asthma." BP 124/80. Urinalysis normal. BUN 7.7 mg%; RBC 3.9 M; Hb. 12 gm.

2. (9-11-44) CC: "Sharp pains in left side radiating to inguinal region." BP 180/100. Left flank tender to palpation. Urinalysis: Trace of albumin, sp. gr. 1.020, RBC 10-20 per hpf, occasional hyaline and granular casts. Hb. 11.5 gm; RBC 3.5 M; BUN 10.5 mg%; PSP 12% excretion in 15 minutes. IVP: "Calcareous densities over each kidney. Left renal pelvis is dilated, believed due to narrowing at the uretero-pelvic junction."

3. (9-13-45) CC: "Severe pain in right lumbar region for past 3 days." Tenderness in right lower abdomen. B. pyocyaneous and coliform bacilli cultured from each ureteral specimen. Urine from right ureter showed many RBC and WBC. RBC 3 M; Hb. 10.5 gm; BUN 15 and 26.5 mg%. X-ray: "No evidence of calculi of right kidney. Calculi still seen in left kidney." Patient's spiking fever returned to normal on "sulfas" and penicillin treatment. Received two transfusions because of drop in hemoglobin to 8.5 gm.

4. (9-23-48) CC: "Severe pain left flank few days duration." BP 130/70. Urea clearance 29.6% of normal standard clearance. Urinalysis: Trace of albumin, few RBC, many WBC. Urine culture: Pyocyaneous organisms. RBC 1.3M; Hb. below 7.5 gm; BUN 21.2 and 14 mg%; CO_2 combining power 48 and 54 vol. %; serum proteins 6.6 gm; blood calcium 11.1 mg%; blood phosphorus 3.3 mg%. Ten blood

transtusions given. On 10-11-48 the patient's left ureter was explored through a left lower abdominal incision. A large calculus was seen in the left ureter at the iliac vessels. A vessel was seen crossing the ureter above this. A section of the inflamed ureter was removed with the stone. The ureter was anastomosed. Pathological examination showed a calculus 1.2 cm in diameter and a segment of chronically inflamed ureter. X-ray: "There is a small irregular stone in one of the middle calyces of the right kidney." X-ray of the chest interpreted as "generalized cardiac enlargement with disproportionate ventricular enlargement."

5. (3-1-49) CC: "Weakness and anemia." BP 120/70. Left incisional hernia. Hb. 7 gm; RBC 2.1 M; BUN 17.3 mg%; alkaline phosphatase 6.4 Bodansky units; reticulocyte count 0.7%; erythrocyte fragility normal. Sternal marrow puncture: "Hypoplasia of erythrogenic series — only 7 normoblasts." X-ray: "Questionable right ureteral calculus." Received 3 blood transfusions.

6. (7-12-49) CC: "Weakness, fatigue, headache." BP 120/80. Retinal arteries show minimal sclerosis. Sternal marrow puncture: 4 erythroblasts, 4 normoblasts, granulocytic series normal, 27 lymphocytes. Urinalysis: Sp. gr. 1.010, albumin plus 1, many clumped WBC. Urine culture: B. coli. RBC 2 M; Hb. 6.5 gm; Mosenthal: Maximum sp. gr. 1.017, minimum sp. gr. 1.010, night specimen sp. gr. 1.013; PSP 17% excretion in 2 hrs. X-ray: "Irregular opacity over right kidney which probably represents stones." Patient received 1000 cc whole blood.

7. (11-4-49) CC: "Weakness, frequency, nocturia, low back pain." Purpuric lesions both arms. BP 140/80. RBC 1.6 M; BUN 20.5 mg%; platelets 305,000. Received 1500 cc whole blood.

8. (1-17-50) CC: "Left flank pain." BP 150/75. Liver palpable 2-3 fgbs. below RCM. BUN 15, 37 and 20 mg%; Mosenthal: Maximum sp. gr. 1.010, minimum sp. gr. 1.006, day urine volume 365 cc, night urine volume 680 cc; blood glucose 111 mg%. On 1-27-50 a nonfunctioning left kidney and ureter were removed. Pathological report: "Left kidney — chronic pyelonephritis and nephrosclerosis." 5500 cc whole blood given to patient. (Patient transfused on OPD basis frequently during interval between readmissions.)

9. (2-20-51) CC: "Headaches, asthmatic attacks, swelling of feet." BP 132/74. RBC 1.9 M; Hb. 6.5 gm; BUN 11.3 and 38.5 mg%. Urinalysis: Many WBC and bacteria. Patient received 1500 cc whole blood.

10. (2-27-52) CC: "Fatigue, leg edema." RBC 1.9 M; WBC 6,100; Hb. 4 gm; BUN 16 mg%; reticulocyte count 0.7%. Bone marrow smear: "Erythrogenic hypoplasia." Blood chemistry studies remained the same except for a serum calcium of 5.7 mEq/L. Coomb's test negative; RBC fragility normal; blood culture negative; sed. rate 34 mm per hour. EKG normal. X-ray chest: "Pronounced general cardiac enlargement." Benign rectal polyp removed. Patient received 3500 cc whole blood.

11. (9-16-52) CC: "Headache and vertigo." BP 170/80. Heart: PMI at the anterior axillary line. Sternal marrow puncture: "Generalized hypoplasia." Patient given 2000 cc whole blood.

12. (12-8-52) CC: "Weakness and anemia." BP 170/70. Liver palpable 3 fgbs. below RCM. She received 4000 cc whole blood.

13. (12-22-52) CC: "Weakness." BP 170/90. Patient had dimness of vision, chest pain, vomiting after transfusions, and some bronzing of the skin. Hemosiderosis and possibly hemochromatosis suggested. Transfusions totaling 3000 cc whole blood given to patient.

14. (3-11-53) CC: "Weakness and dizziness." Skin bronze, purpura of both arms. BP 130/70. Blood glucose 101 mg%; BUN 79 mg%; platelets 136,000. Blood transfusions totaled 2500 cc whole blood.

15. (4-20-53) CC: "Frontal headache and leg swelling." BUN 32.5 mg%. Transfusions totaled 1500 cc whole blood.

16. (6-11-53) CC: "Weakness, easy bruising, jaundice." BUN 36 mg%; Hb. 4.9 gm; platelets 79,000; blood glucose 113 mg%. Urinalysis: Granular casts. Patient received 2000 cc whole blood.

17. (8-5-53) CC: "Shortness of breath." Lower 2/3 left side of chest exhibits pleural effusion. Disappeared on treatment after 10 days.

18. (9-16-53) For transfusions. BUN 35 mg%.

19. (11-22-53) For fluid in chest. Responded to treatment.

20. (1-18-54) CC: "Weakness and headache." BUN 50 mg%. Blood transfusions totaled 2000 cc whole blood.

- Final Readmission (4-7-54)

CC: "Severe substernal pain and cough one day before admission." BP 150/80. T. 102°. Consolidation both bases. RBC 2.7 M; Hb. 6.8 gm; WBC 2,350; BUN 85 mg%. EKG: "Some degree left ventricular hypertrophy." X-ray of chest: "Some clearing of bases." Temperature subsiding. On 4-18-54 died after 24 hours of drowsiness, semiconsciousness and irregular pulse.

Discussion

JOHN J. BLIZZARD, M. D.: My clinical impression after reviewing the patient's first admission to the hospital and the past history is that the findings are classical for renal lithiasis. The etiology of the stone formation is not quite as obvious. At that time there was no evidence of renal insufficiency or obstructive uropathy or of any other causes of renal lithiasis such as gout, hypervitaminosis D, milk alkali syndrome, metabolic acidosis, metastatic bone disease, Cushing's syndrome, osteoporosis and the immobilization syndrome of Deitrick and Shorr. I think she probably represents one of the 5% of patients with renal stone who have hyperparathyroidism as an etiology.

The patient had asthma and sinusitis, both being probably on an allergic basis. The combination of renal involvement and asthma leads one to suspect disease entities such as Wegener's granulomatosis or other forms of collagen disease such as polyarteritis nodosa and McCoombs vasculitis but the data for substantiation is lacking.

Since the patient had 21 readmissions, a brief review of each one is necessary to appreciate the course and progress of her disease state.

The first readmission was for an acute bronchial asthmatic attack which responded to treatment. Calculus of the left kidney was the reason for the second readmission. The intravenous urogram was interpreted as demonstrating bilateral calcareous densities over each renal area and evidence of obstructive uropathy on the left due to narrowing at the uretero-pelvic junction. Although the BUN was within normal limits, urinalysis revealed a trace of albumin and a PSP excretion of only 12% after 15 minutes, demonstrating impairment of kidney function.

Bilateral pyelonephritis and possible right renal lithiasis necessitated the third readmission. The infection responded to treatment but of interest is that for the first time the BUN is slightly elevated

and an anemia requiring two blood transfusions is noted. What are the possible etiological agents for this anemia? Is it due to chronic blood loss from the kidneys? Is this the anemia of chronic renal insufficiency?

I doubt that it is due to either of the above mentioned causes. There is no evidence of any profound hematuria and the renal function, although somewhat impaired as measured by the low PSP excretion and slightly elevated BUN, does not appear to be of a magnitude to cause a relatively severe anemia. There is no definite evidence of hemolysis and, as mentioned later in the protocol, the reticulocyte count is normal. Although chronic infection may be the cause of this anemia, more definite evidence as to the etiology is available in the later readmissions to the hospital.

Striking changes

Studies during the fourth readmission demonstrate striking changes in the patient's clinical status. There is a profound normocytic, normochromic anemia of 1.3 million RBC and a hemoglobin below 7 grams requiring ten whole blood transfusions for correction. Although there was a very mild degree of azotemia the urea clearance was only 29.6% of normal standard clearance. Blood calcium was 11.1 mg% which is top normal and blood phosphorus 3.3 mg%. X-ray of the chest showed evidence of cardiac enlargement primarily of the left ventricular type for the first time. Surgery of the left kidney substantiated the x-ray findings of a uretero-pelvic narrowing due to an aberrant vessel.

The fifth readmission was for study and treatment of her profound anemia. The initial hemogram revealed a hemoglobin of 7 gm and RBC of 2.1 million. Sternal marrow puncture was interpreted as hypoplasia of the erythrogenic series with only 7 normoblasts being demonstrated on the single study. The bone marrow findings are of interest inasmuch as the anemias of renal insufficiency, chronic blood loss, hemolytic and chronic infectious states give rise to hyperplasia rather than hypoplasia of the erythrogenic series.

On the basis of her hypoplastic bone marrow and normal reticulocyte count of 0.7% the diagnosis of a hypoplastic anemia, etiology unknown, must be entertained. The hypoplasia in this patient is only in the erythroid elements without affecting the myelogenous or thrombocytic series

although usually all bone marrow elements are depressed in a hypoplastic anemia.

Chronic

Anemia is the cause of her sixth readmission. Repeat sternal marrow puncture confirms the findings of hypoplasia of the erythroid series noted by the first marrow aspiration. Of interest is that the patient is normotensive although renal function studies show chronic renal disability.

During her seventh readmission purpuric lesions over both arms are observed although the platelet count is within normal limits. Patients with hypoplastic anemia usually have a prolonged bleeding time and poor clot retraction but I doubt that the purpura is on this basis in view of the normal platelet count.

Hepatomegaly is noted at the time of the eighth readmission. The patient received eleven whole blood transfusions and a left nephrectomy is performed which demonstrates histologically chronic pyelonephritis and nephrosclerosis.

The ninth readmission is for her asthmatic attacks and pedal edema. These symptoms may be due to right sided heart failure or a combination of bronchial asthma and edema secondary to the profound anemia. Another bone marrow aspiration is done during her tenth readmission. The interpretation is again erythroid hypoplasia. A benign rectal polyp is excised but this finding has no bearing on the clinical picture.

Significant finding

Attempts to demonstrate a hemolytic component as an explanation of the anemia are unsuccessful with the Coomb's test (erythrocyte fragility and reticulocyte count within normal limits). Serum calcium is 5.7 mEq/L., which is slightly elevated. I believe that this is a very significant finding. Severe renal disease is accompanied by a negative calcium balance and hypocalcemia. The persistence of an elevated serum calcium in spite of this patient's severe renal disease is a definite clue to the diagnosis of hyperparathyroidism.

The eleventh and twelfth readmissions are for treatment of her anemia and on the thirteenth readmission bronzing of the skin is observed. This is probably due to hemosiderin deposits secondary to the many blood transfusions received over the years.

Purpura recurs during the fourteenth readmission. Platelets are 136,000 and the BUN is 79 mg%. The bruising tendency can

be explained on the basis of the azotemia and the relative thrombocytopenia.

Intractable frontal headache and leg edema are the reasons for the fifteenth readmission. Besides cardiac decompensation, the basis of her severe headache may be cerebral petechiae and edema.

The interesting finding on the sixteenth readmission is the thrombocytopenia of 79,000 platelets indicating that the marrow is becoming aplastic as far as these elements are concerned.

Heart failure

The seventeenth readmission is for treatment of a left sided pleural effusion. I believe this is evidence of left ventricular heart failure of a high output type secondary to the profound anemia in an individual over 70 years of age with an additional component of arteriosclerotic cardiovascular disease. Whether or not there is an acquired cor pulmonale due to her chronic pulmonary disease is difficult to say. The eighteenth through the twentieth readmissions are for transfusions and treatment of pleural effusion.

The final readmission mentions for the first time severe substernal pain. What is the etiology of this pain? Is it coronary insufficiency with myocardial infarction or is it a pulmonary infarction in view of the consolidation in both bases? I think the most logical cause for her severe substernal pain is a combination of ventricular failure and physiological coronary insufficiency secondary to her profound anemia. Electrocardiogram did not demonstrate any infarction pattern. In spite of treatment, with evidence of improving, patient became comatose and died 24 hours later.

In summary, a combination of several diagnoses explains this long clinical picture. I think her renal lithiasis is on the basis of hyperparathyroidism secondary to a parathyroid adenoma, in spite of the lack of clearly substantiating blood chemistry studies. However, when one considers that the chronic renal disease this patient exhibited tends to have profound calcium loss and negative balance and a great deal of phosphate retention, it is significant to note that the serum calcium is of a high normal to slightly elevated value and the phosphorus remains within a normal range, which makes me feel that the hyperparathyroidism is the compensating factor. Furthermore, in primary hyperparathyroidism due to an adenoma, recent data has demonstrated that

at times approximately 30% of the patients may have normal blood calcium and phosphorus values.

There is chronic pyelonephritis as a result of the many recurrent infections and the congenital obstructive uropathy. E. coli and Pseudomonas organisms were the most frequent infecting bacteria. Although these are not ammonia splitting organisms which cause an alkaline urine, it has been noted that Pseudomonas may induce an alkaline urine and this factor in turn renders the calcium ions less soluble and more prone to stone formation.

Etiology unknown

The patient had a profound anemia which was at the time of onset primarily that of erythroid hypoplasia with progression over the years to an aplastic type. The etiology of this disease in this patient is unknown even though anemia is usually associated with chronic renal disease.

Bronchial asthma has been present for many years but does not seem to be a problem in management if the record is accurate. Whether or not pulmonary emphysema and interstitial fibrosis resulted from the asthma, with secondary cardiac embarrassment, is difficult to say.

Hemosiderosis secondary to multiple blood transfusions developed later in the course of the patient's disease but does not appear to have been an aggravating influence.

The patient's death was most probably of cardiac origin superimposed on the underlying chronic renal disease, profound anemia and some pulmonary insufficiency.

In conclusion my diagnoses are: Hyperparathyroidism (etiology, parathyroid adenoma)

Kidney:

- Chronic pyelonephritis
- Nephrosclerosis
- Congenital obstructive uropathy (operative diagnosis)

Blood:

- Hypoplastic anemia (etiology unknown)
- Hemosiderosis due to multiple blood transfusions

Pulmonary:

- Chronic bronchial asthma, allergic type
- Pulmonary emphysema

Cause of death: Coronary insufficiency and cardiac failure (high output type) due to the profound anemia.

ROBERT S. RICHARDS, M.D.: Films of the abdomen in 1941 demonstrate bilateral renal calcifications. Further films obtained in 1948 show a large stone from

the left kidney has descended into the lower portion of the ureter. In 1950 an intravenous pyelogram demonstrates a nonfunctioning left kidney. From 1948 onward films demonstrate cardiomegaly.

While not pathognomonic, the presence of bilateral renal calculi is consistent with hyperparathyroidism and the moderate cardiac enlargement is nonspecific.

CLARK E. BROWN, M.D.: Dr. Blizzard has given us a complete and highly perceptive analysis of this elderly white woman's malady. Perhaps the most interesting aspect of this woman's illness is the long history of her renal disease, a 30-year siege of bilateral renal calculi. You will recall that she had a large calculus removed from her left ureter in 1948, which was followed two years later by a left nephrectomy.

The left kidney weighed only 81 grams, was shrunken and nodular with a granular, slightly dilated pelvis. An aberrant artery was described at the lower pole. The first slide taken from this kidney (Figure 1) shows a severe chronic pyelonephritis with extensive glomerular and arterial sclerosis and generally dilated, atrophic tubules filled with so-called colloid casts. Numerous foci of calcium were scattered in the walls of the tubules, one of which is shown.

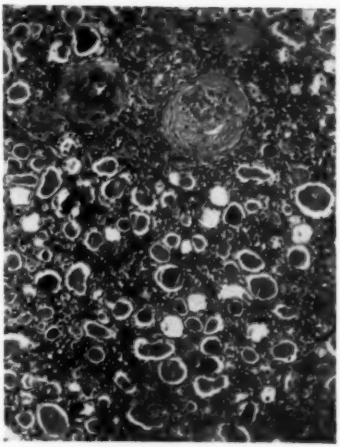


FIGURE 1

Grossly normal

Following this operation, the patient lived and was ambulatory for an additional four years with a right kidney which at postmortem weighed 100 grams and was identical in appearance with the left. No stones were present in this kidney at this time, although they had been repeatedly demonstrated during the past ten years. The ureter and bladder appeared grossly normal although histologically chronic inflammation of the former was noted.

The role of the parathyroids

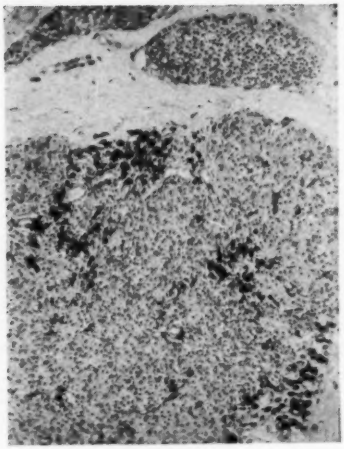


FIGURE 2

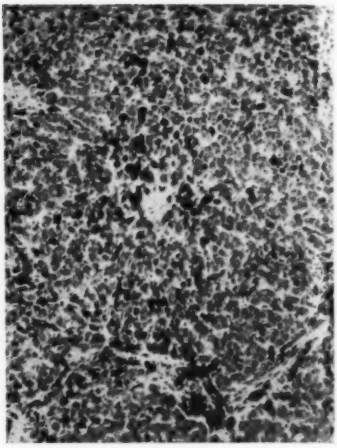


FIGURE 3

in this 30-year history of renal calculi is interesting, particularly as to whether their implication was of a primary or secondary nature. The postmortem showed parathyroids of normal size except for one which measured 1 cm in diameter and was subcapsular. Microscopically, this gland was composed of cords of oxyphilic cells and clear cells which replaced all the fat spaces in the gland. This we interpreted as an adenoma because of its increase in size, difference in microscopy from the three other glands which showed only chief cells, and because of its increased cellularity. Figure 2 shows these changes as well as an increase in a granular pigment deposition which we will touch on next.

Thus, we feel that this patient's renal calculi were initiated years ago by a small parathyroid adenoma, and that her hyperparathyroidism was primary. Subsequently, a severe degree of pyelonephritis developed.

Marrow depression

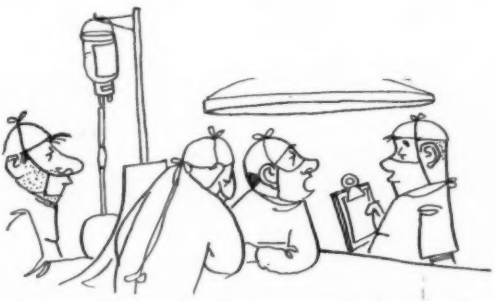
The final puzzling feature of this patient's illness is her severe and prolonged anemia, requiring more than 50 blood transfusions. We feel that the cause of this anemia is marrow depression because aspiration of the marrow shows only a few normoblasts and erythroblasts; reticulocytes

were never elevated in her peripheral smears and fragility studies were always negative.

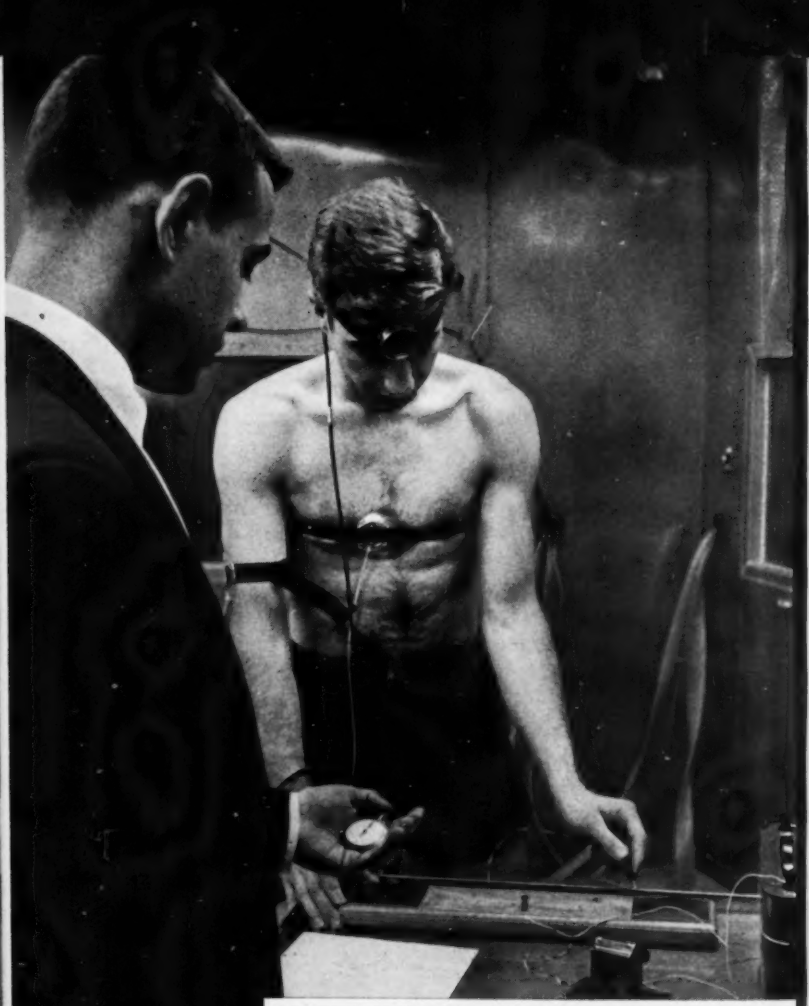
No serum iron studies were performed, but no increase was noted in stool or urine urobilinogen determinations. So we have assigned a hypoplastic cause to her anemia on the basis of chronic inflammatory renal disease, possibly from an assumed loss of erythropoietin from extreme diminution of renal substance. The consequences of attempts to correct her anemia were shown in a widespread deposition of hemosiderin pigment in her liver, spleen, pancreas, bone marrow, skin and lymph nodes.

Her skin had a grayish brown shade. The liver weighed 1450 grams and was firm, elastic and copper brown in color. Histologically, the Kupffer cells were engorged with iron positive pigment and to a lesser extent liver cells contained similar granules. Fibrosis was beginning to occur around this pigment in the periportal region (Figure 3). Similar engorgement of macrophages was noted in the pancreas, spleen, marrow and nodes. The pancreatic acinar cells in addition contained abundant pigment.

The heart weighed 300 grams and was firm and brown. The marrow was hypocellular, particularly in the red cell series. The bone spicules in the vertebrae, ribs and tibia were thin and appeared porotic, but marrow fibrosis and cysts were absent, eliminating the osteitis fibrosa cystica component of hyperparathyroidism. The remaining viscera were essentially normal.



"I've found a bit of diseased bowel here. Call the family, another surgical consultant and the insurance agent..."



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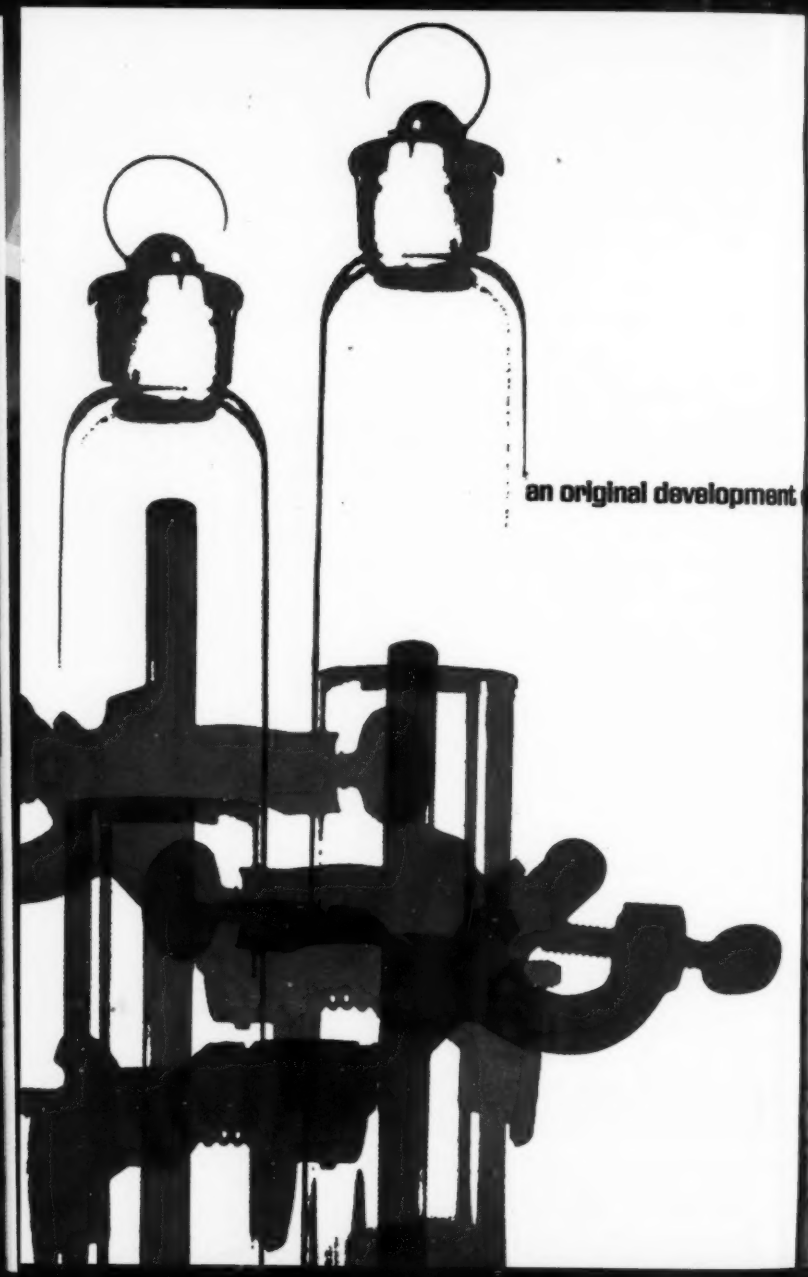
one of a series on resident and intern centers

Major teaching affiliations with Jefferson Medical College and the Graduate School of Medicine, University of Pennsylvania, provide Lankenau's house officers with opportunities for instruction in the specialties. All patients are considered teaching patients.

Founded 100 years ago by a group of German-born physicians, Lankenau Hospital (chartered as The German Hospital of the City of Philadelphia) was originally a 50-bed institution in a former residential dwelling in a rural section of the city. The resident staff consisted of one physician who also doubled as apothecary.

Lankenau moved to its present 93-acre site in Overbrook, a Philadelphia suburb, in 1953. The main hospital building, which has a capacity of 347 beds and 56 bassinets, won a National First Honor Award for architect Vincent G. Kling. Besides the many modern conveniences, on the lower floors are an auditorium seating 350 and the country's only Health Museum within a hospital. Both of these facilities are used extensively in the health education program which Lankenau sponsors as a service to the community. Since 1954, more than 250,000 persons

u Hospital PHILADELPHIA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Lankenau Hospital moved to its present 93-acre site in Overbrook, a Philadelphia suburb, in 1953. Its strikingly contemporary buildings won a National First Honor Award for architect Vincent G. Kling.

have seen the Museum, health films, and "Pandora," the talking, transparent woman, who delivers a graphic five-minute lesson in anatomy. This is in keeping with the philosophy that a hospital should be a part of the community, playing an active role in the dissemination of knowledge relevant to preventive medicine.

In 1955, a doctors' office building, providing private offices for 70 of the approximate 165 active staff members, was added to the hospital complex. The convenient location of this building permits the attending staff to devote more time to teaching functions. In 1959, the latest addition, a medical science building, was opened. This is a multipurpose structure which houses the ambulatory and minimal nursing care patients and the new research division. The patient section has a potential total of 126 beds of which only 50 are in current use.

The Division of Research coordinates all research activities at Lankenau, maintaining close cooperation between clinical and research personnel, and assisting the teaching and service functions of the hospital. Research facilities include a climatic chamber and metabolic ward. Current research includes problems in connective tissue disorders, cardiovascular diseases, cancer, and work physiology including occupational medicine and rehabilitation. Research projects number more than 40, employ a staff of 50 and are aided by $250,000 in research grants.

Special medical staff committees, in conjunction with a full time member of the medical staff (the medical administrative liaison officer), are responsible for the educational and administrative aspects of the house staff programs. Emphasis is on education with the service aspects being secondary. The house staff is not responsible for routine service duties which detract from education.

In 1951, as a solution to the problem created by the continuing decline in number of free patients, the medical staff agreed to the use of all private patients for the teaching of medical clerks, interns and residents. The house staff is responsible for initiating and continuing in the care of private patients in close conjunction with the respective member of the attending staff. The ward attending staff and members of the student teaching group see and discuss any private patients they consider necessary during their periods of bedside instruction.

The medical staff is of the closed voluntary type; 80 percent of the 165 members have academic appointments in one of the five schools of medicine in the Philadelphia area.

Lankenau, with 397 beds—exclusive of bassinets—has an average daily census of 331. During the past year there were 13,977 admissions and 26,818 outpatient department visits of which 8,179 were seen in the emergency room. The autopsy rate was 64 percent.

A total of 12 rotating internships and 21 residencies is offered. Internships are obtained through the National Internship Matching Program while residencies are awarded on an individual basis. Appointments are not restricted to any race, sex or creed. Graduates of foreign medical schools must be certified by the Educational Council for Foreign Medical Graduates.

Affiliations

Major teaching affiliations are maintained at both the undergraduate and graduate level. Third year medical and fourth year surgical clerkships are provided for students of Jefferson Medical College. The Graduate School of Medicine of the University of Pennsylvania affiliates for instruction in the surgical specialties.

Approximately one-third of the the third year class receives all their clerkship instruction at the Lankenau Hospital. In addition to the voluntary attending staff's participation, there are five salaried, half-time instructors for 20

clerks (assigned for 12-week periods) with each instructor being responsible for only four clerks.

Residents in ophthalmology and orthopedics from the Graduate Hospital of Philadelphia spend six months as affiliates in their respective specialties. Surgical and medical residents from the Lankenau Hospital affiliate at the Jefferson Medical College Hospital for six months of thoracic surgery and for one year of medical specialties, respectively.

Interns receive $2100 a year. Resident stipends are: first year $2400; second year $2700; third and fourth years $3000. Maintenance consisting of all laundry, food, a room in the house staff quarters and malpractice insurance are provided free of charge. All house staff officers furnish their own uniforms and conductive shoes. House officers pay for one-half of the Blue Cross premium for which they and their dependents receive complete in- and outpatient services including all prescription items at no additional cost.

Two apartment houses are maintained by the hospital for the personnel. One unit, located on the hospital grounds, is primarily for the married house staff's use. Apartments, furnished or unfurnished, with all utilities except telephone service, are assigned without charge to married house staff officers commensurate with their individual needs. If the married house staff officer desires to live elsewhere, a $75 a month rental allowance is granted.

Each resident has two weeks annual vacation. Vacations for interns are not permitted by the Pennsylvania State Board of Medical Education and Licensure. An intern and resident loan fund is maintained from which money can be borrowed at a very low interest rate.

Recreation areas in the house

PIONEER HOSPITAL

Despite its modest beginnings, Lankenau Hospital pioneered in many phases of hospital care. Before its first bed was occupied, the hospital initiated a first-in-America public service—hospitalization insurance. The charter specified: "Unmarried persons paying regularly 25 cents a month shall be entitled to free admission as patients."

It also provided "that patients shall be admitted without exclusion of country, creed or color."

Later—in an era when the nurses in most American hospitals were untrained domestics — Lankenau established a professional nursing staff with the importing of a corps of seven

staff quarters consist of separate ping-pong and television rooms. There are two tennis courts on the hospital grounds, and a swimming pool on an adjacent school's property is available for use in the summer. A medical staff sponsored intern and resident recreational fund provides tickets for music, cultural and sports events which are distributed among the house staff.

The library contains approximately 4000 volumes and receives 146 different journals. There is a lending service with the renowned Philadelphia College of Physicians library and any medical literature can be obtained by the hospital's full time librarian upon request.

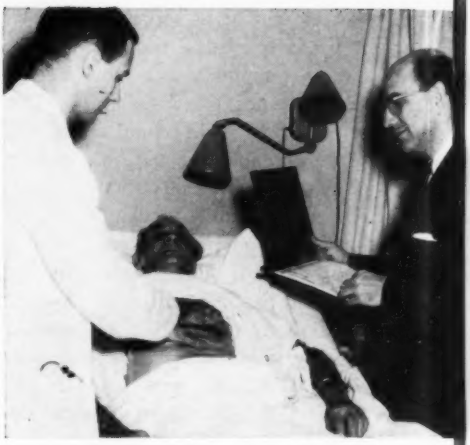
The 12 internships offered are of the rotating type with five months devoted to medicine and its specialties, one month in the emergency room and two months each on pediatrics, surgery and its specialties, and obstetrics-gynecology. The internship is geared to prepare individuals interested in general practice and to provide a varied broad base of practical experience for those entering into residency training.

Intern coverage is arranged to allow for an average of 15

Lutheran Deaconesses who had trained at Kaiserwerth, Germany. The hospital's School of Nursing was indirectly the result of the Spanish-American War. During the war, a hospital train equipped by Lankenau brought in 275 soldiers stricken with typhoid, a circumstance which so taxed the Deaconesses that the following year a nursing school was founded. Currently it offers a three-year accredited course and averages 60 graduates annually.

In 1872, through the generosity of John D. Lankenau, in whose honor its was subsequently renamed, the hospital moved to greatly expanded, elegantly-Victorian quarters in a more populous section of the city. It continued to pioneer, numbering among its "Philadelphia firsts" the establishment of a bacteriological and chemical research laboratory in 1889, introduction from Germany of Koch's lymph for treatment of tubercular diseases in 1890, importation of the Behring diphtheria serum from Germany in 1894, establishing an x-ray laboratory in 1896, the creation of a follow-up service in 1921, and setting up the Marine Experimental Station for study of cell growth in lower animals at North Truro, Cape Cod, in 1931. This later developed into the world-famous Institute for Cancer Research.

new patients a week and a daily average census of 25 patients. Teaching sessions, daily rounds, and major service weekly conferences and rounds are part of the program. Interns work closely with and under the supervision of the resident staff; the extent of the responsibility for the management of patients is commensurate with the individual intern's interest and ability.



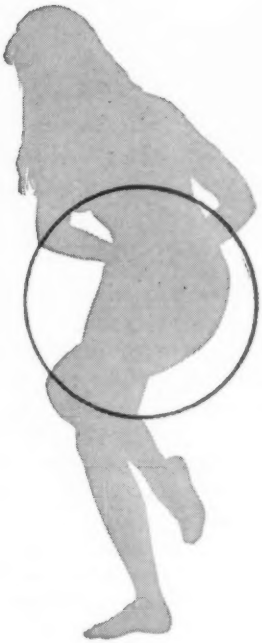
Patient examination, instructor observes.

Medicine

The medical residency program is approved for three years and offers positions for six residents, two in each year of the program. It is under the direction of a subcommittee on medical residency training. There are two medical services and each first year resident is assigned for six months to each service. The entire second year is spent on affiliation at the Jefferson Medical College Hospital for specialty services training on a clinical fellowship level. Specialty services available for training in periods of not less than three months are cardiology, cardiopulmonary physiology, endocrinology, metabolic research, hematology, gastroenterology, infectious diseases and neurology. Each resident in the third year is "senior" for the entire year on one of the medical services and, if it is desired, half of this time may be spent in the research division.

Junior Residents, under the guidance of the senior resident, act in a supervisory capacity over interns and medical clerks. They arrange for conferences, make daily ward rounds with members of the attending staff who have demonstrated teaching ability, and attend specialty rounds which average three a week. The two weekly general medical clinics which are considered the "senior

In female urethritis referred pain complicates diagnosis



Pain in the groin, suprapubic region, thighs and lower back is often caused by urethritis but, as a result of negative urinary findings, is attributed to other organs. Direct examination of the urethra helps localize the origin of referred pain, evidence of urethral inflammation calling for local therapy.

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LANKENAU HOSPITAL RESIDENCIES

SERVICE	CHIEF	RESIDENCIES TOTAL	(YEARS) LENGTH
Medicine	Daniel B. Pierson, Jr. Edward L. Bortz	6	3
Obstetrics-Gynecology	Ross B. Wilson	3	3
Pathology	Clark E. Brown	4	4
Surgery, General	J. Montgomery Deaver Gilson Colby Engel	8	4
Urology	Charles A. W. Uhle	Included in General Surgery	
Neurosurgery	Robert K. Jones	Included in General Surgery	
Orthopedics	Jesse T. Nicholson	Included in General Surgery	
Plastic Surgery	Hans May	Included in General Surgery	

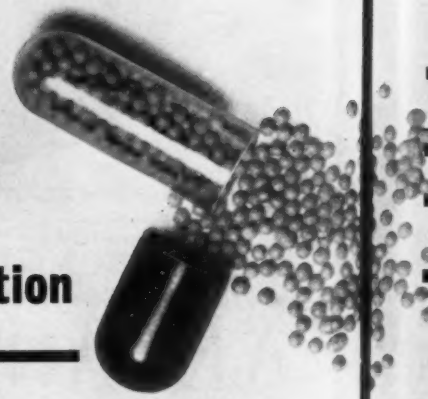
resident's clinic" are attended by the resident staff with a member of the attending staff present. The house staff writes orders on all patients, private or ward, admitted to the medical services. All admissions to the ward beds are arranged through the resident staff.

Obstetrics and gynecology

The residency program in Ob-Gyn is approved for three years with three residencies offered. The first year resident is assigned to obstetrics and the three weekly clinics. He receives training in cystoscopy and anesthesiology and attends selected lectures in pathology and physiology at the Graduate School of Medicine of the University of Pennsylvania. The second year is divided equally between obstetrics and gynecology, and the third year is spent entirely on gynecology. By the third year, residents perform major gynecological procedures under the supervision of board certified gynecologists.

An experimental program aiming toward the development of well trained clinical research personnel was instituted two years ago in collaboration with the research division. By extending his total time to five or six years, the resident can do valuable investigative work and at the same time meet his specialty training requirements. During these extra years of training, the resident

for the first time adequate iron in convenient sustained-release form for more efficient assimilation



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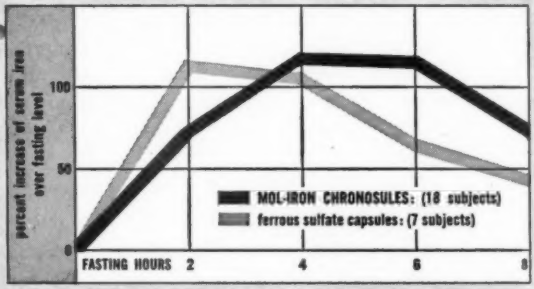
- Thus, all the advantages of Mol-Iron, the specially processed, co-precipitated complex of ferrous and molybdenum compounds, now in the form most conducive to efficient assimilation.

Comparative patterns of gastrointestinal absorption of iron following standardized test doses of Mol-Iron Chronosules and of ferrous sulfate capsules (normal fasting adults)



The curve for ferrous sulfate reflects a sharply increased absorption of iron during the first two-hour period, and a progressive waning of absorption during each of the succeeding test intervals. In contrast, the curve for Mol-Iron Chronosules mirrors a sustained and efficient rate of iron absorption over a full six-hour span following oral intake.

Dosage: Adults—one Mol-Iron Chronosule daily. In severe anemia, one Chronosule twice daily. Children—one Mol-Iron Chronosule daily. **Supplied:** In bottles of 30 Chronosules.

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Conferences play an important role in house staff education at Lankenau.

receives yearly stipends both as a postdoctoral fellow and as a resident.

Pathology

The pathology residency is under the supervision of Dr. Clark E. Brown, assisted by two other full-time, board certified pathologists and a biochemist. During the fiscal year 1959-1960, there were about 250,000 laboratory examinations and 222 autopsies performed.

Surgery

The surgical residency program is approved for four years and utilizes eight residents, two in each year of the program. There are two surgical services at Lankenau Hospital, and the schedule is so arranged that each surgical service operates every other day, attends to the surgical clinic and has its conferences the other days of the week.

The first year residents spend six months on each service. The second year residents spend six months on urology and neurosurgery and six months on orthopedics and plastic surgery. The third year is divided into six months on pathology and six months in thoracic surgery at the Jefferson Medical College Hospital. In his fourth year, the resident is senior for the entire year on one of the two surgical services. Approximately 300 major procedures are done by each resident in his senior year. Residents also assist in the teaching of the fourth year students from Jefferson Medical College, on affiliation for surgical clerkships.

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1. Clein, N. W.: Pediat. Clin. North America, Nov., 1964, pp. 949-962.

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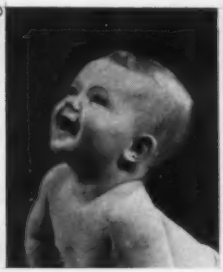

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R. F. Hosford, M.D.

Guest Editorial

Adjusting to the Hospital Environment

So much technical material must of necessity be crowded into the curriculum of the medical student that little if any emphasis is placed on what is expected of him by the hospital when he becomes an intern or resident or a newly appointed member to the staff of a hospital. Staff physicians as well as house staff members have certain obligations to the hospital, just as the hospital has certain obligations to the house staff and medical staff. Recognition of these obligations is essential for the smooth running of the hospital and for the most effective patient care.

The medical staff and the hospital together must do certain things in order to maintain standards that will insure full accreditation of the hospital by the Joint Commission on Accreditation of Hospitals. The bylaws, rules and regulations of the medical staff should spell out clearly the duties and responsibilities of the staff members and the various committees of the staff. Each physician, at the time of his appointment, should be given a copy of this professional bible with which he is expected to familiarize himself and is then required to sign his name to a master copy indicating his willingness to abide by this document. It would be a worthwhile educational experience if the members of the house

an added measure of protection for little patients

against relapse
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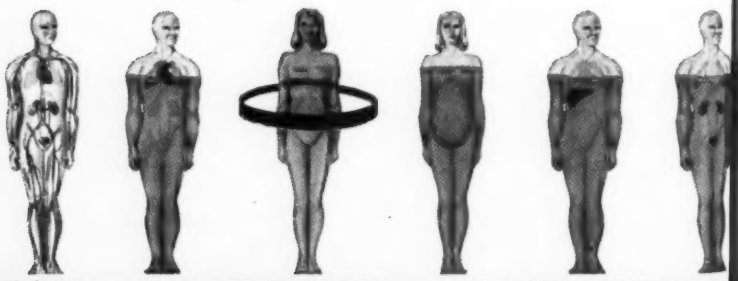

HYPERTENSION CONGESTIVE FAILURE PREMENSTRUAL TENSION EDEMA OF PREGNANCY CIRRHOSIS WITH ASCITES RENAL E

March

R. F. HOSFORD
Director
Lankenau Hospital

staff read the medical staff bylaws of the hospital in which they are serving. I am sure the administrator would be glad to make this possible upon request.

The hospital is the doctor's workshop regardless of whether or not he likes that terminology. It has cost some people a lot of money, most of whom had no connection with the hospital. Their contribution was intended to provide a vital service to the community. Staff physicians, therefore, have an obligation to contribute something in return for the use of these facilities. They should willingly carry their share of the hospital's teaching program for student nurses, interns and residents, as well as to serve in the outpatient clinics. When the interns and residents, who have benefited through instruction they have received from staff members, receive an appointment to the medical staff of a hospital they, in turn, should expect to contribute some portion of their time in a like manner.

I should like to offer a few pointers that I think might help the young physician to make a good adjustment to his hospital environment, in the hope that he will be disposed to give them thoughtful consideration:

1. Don't become so engrossed in the scientific phase of your profession that you lose sight of the patient as a human being.

2. Don't throw your weight around under the mistaken idea that you are making an impression on others as regards your importance.

3. Don't prescribe expensive drugs along with promiscuous x-ray and laboratory tests, if less expensive drugs and procedures will accomplish the required results. Patients today are very conscious of the cost of medical care.

4. Be considerate of those below your professional rank. You often need their cooperation which they will freely give to those they like but give sparingly to those who assume a superior attitude.

5. Don't make most of your decisions on the basis of what is in it for you. People who get the most out of life are those who are willing to give a little more than they expect to get in return.

6. Don't underrate the value of public relations. Grateful patients and their relatives help to support our hospitals and they also refer other members of their families and their friends to physicians who have gained their confidence and respect.

7. Above all, keep an open mind. There will always be newer and better ways of practicing medicine and the best doctors are those who keep abreast of the times.

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no "cumulative sedative drag" Since these two components have essentially the same duration of action, BUTIBEL makes possible an even, time-matched therapeutic continuity for balanced control of both tension and spasm, without the "cumulative drag" so many patients experience with phenobarbital.

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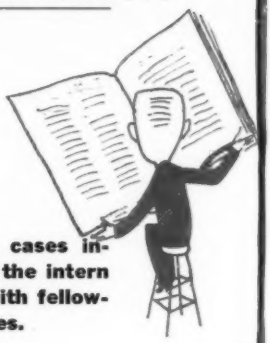
Tax Court: Physicians and Income Taxes . . .

MD Tax Cases



Here is a review of recent income tax cases involving physicians. Of special interest to the intern and resident are several rulings dealing with fellowship grants and cost-of-living allowances.

George A. Friedman, M.D., LL.M.

A doctor in the state of Washington had his license suspended for eight months by a summary proceeding of the medical disciplinary board for conviction of income tax evasion.

A California surgeon who kept two sets of books received a stiff prison sentence for reporting income of $18,000 and $20,000 for two years when he actually made over $30,000 each year.

An ophthalmologist paid the 50 percent fraud penalty on income from five of the twelve years under investigation by Internal Revenue when they finally caught up with him.

Just how do the Internal Revenue agents find out a doctor is making more than he is reporting? Tips from disgruntled employees prove profitable both to the employees and to the government. The "double entry" California surgeon was caught as a result of anonymous telephone calls made by his former secretary who had had charge of his office and books for several years.

A Brooklyn doctor's troubles began when a newspaper carried an account of the fees paid to him and other named doctors by a medical service. The fraud squad was assigned to check their returns.

Internal Revenue keeps an eye on all litigation. Matrimonial

conflicts in particular provide ripe pickings.

Substantial understatement of income will make the agent auditing the returns suspicious, particularly if he sees the office address and/or home address are in expensive neighborhoods, or the physician maintains several expensive cars.

Proof of fraud

There are several ways in which an agent can reconstruct a doctor's actual income. In one case a physician's unreported income was reconstructed by an examination of his patients' cards. Fraud penalties in this case were sustained because the amounts omitted were too large and the practice of under-reporting extended over too long a period to have been the result merely of error.

Hospital records are another source of information. The hospital must disclose names and addresses of a doctor's patients. The agent may then interrogate patients since "the public interest in the collection of taxes . . . outweighs the private interest of the patient to avoid embarrassment resulting from being required to give the revenue agent information as to fees paid the attending physician."

Accountants' records are not privileged and may be subpoenaed by tax agents.

Banks constitute a major source of information and records. In a case where the doctor failed to report substantial professional earnings for the years 1944-1950, the examining agent pointed out to the court that the doctor had failed to reveal that he had accumulated cash in 37 different savings banks totalling over $120,000.

Net worth

The Tax Commissioner most often proves his cases against doctors by the net worth method. He proves that the doctor is worth a lot more than his taxes would indicate.

A physician who had a substantial income from his medical practice was also a shrewd businessman. He withdrew from the stock market prior to the 1929 crash, and took all of his money out of the banks shortly before they closed in 1933. He also owned an optical laboratory.

The Tax Commission obtained bank statements, proved that he was a frequent visitor to his safe-deposit box, ascertained that he maintained several brokerage accounts in his wife's name and did not report certain income from

his laboratory or his practice. Agents also examined his living expenses: he maintained a large house, had several maids and two cars. Inventory was taken at the laboratory.

The tax court was satisfied that the doctor had committed fraud with intent to evade taxes.

The Commissioner is not always upheld on use of the net worth method. It is used only when the taxpayer's books are inadequate. In a 1957 Tennessee case, a doctor convinced the court his records were properly kept and were a true record of his income. Substantially all of the records were available for inspection.

Tests of their accuracy were made by direct correspondence with patients, by comparison of taxpayer's available time (after deducting that part of the work day spent in teaching and charity work at a hospital) with records of patients treated. Large cash transactions were shown to be loans from the taxpayer's father-in-law.

Cash hoards

Quite often a taxpayer defends a net worth case by claiming he had accumulated a cash hoard over the years which he is currently spending or depositing. The courts must determine whether these hoards indicate frugality or fraud.

In a 1952 Alabama case, the revenue service assessed taxes against a physician, suggesting that his returns for the prior few years did not report sufficient taxable income to account for the physician's net worth in 1945. The court accepted the physician's testimony about the amount of cash he had on hand at the beginning of a period for which an assessment on a net-worth computation had been made.

In a similar case a physician deposited almost $40,000 in the bank in 1944 and 1945. The government claimed this as unreported income for those two years. The physician proved it was money brought to the United States when he came from Germany in 1938.

Constitutional rights

The taxpayer has a right to refuse an agent access to his books and records where they would "tend to incriminate him," that is, where they would be *the basis of criminal charges*. This immunity extends to the books of a partnership.

While the immunity extends to his lawyer, it does not extend to

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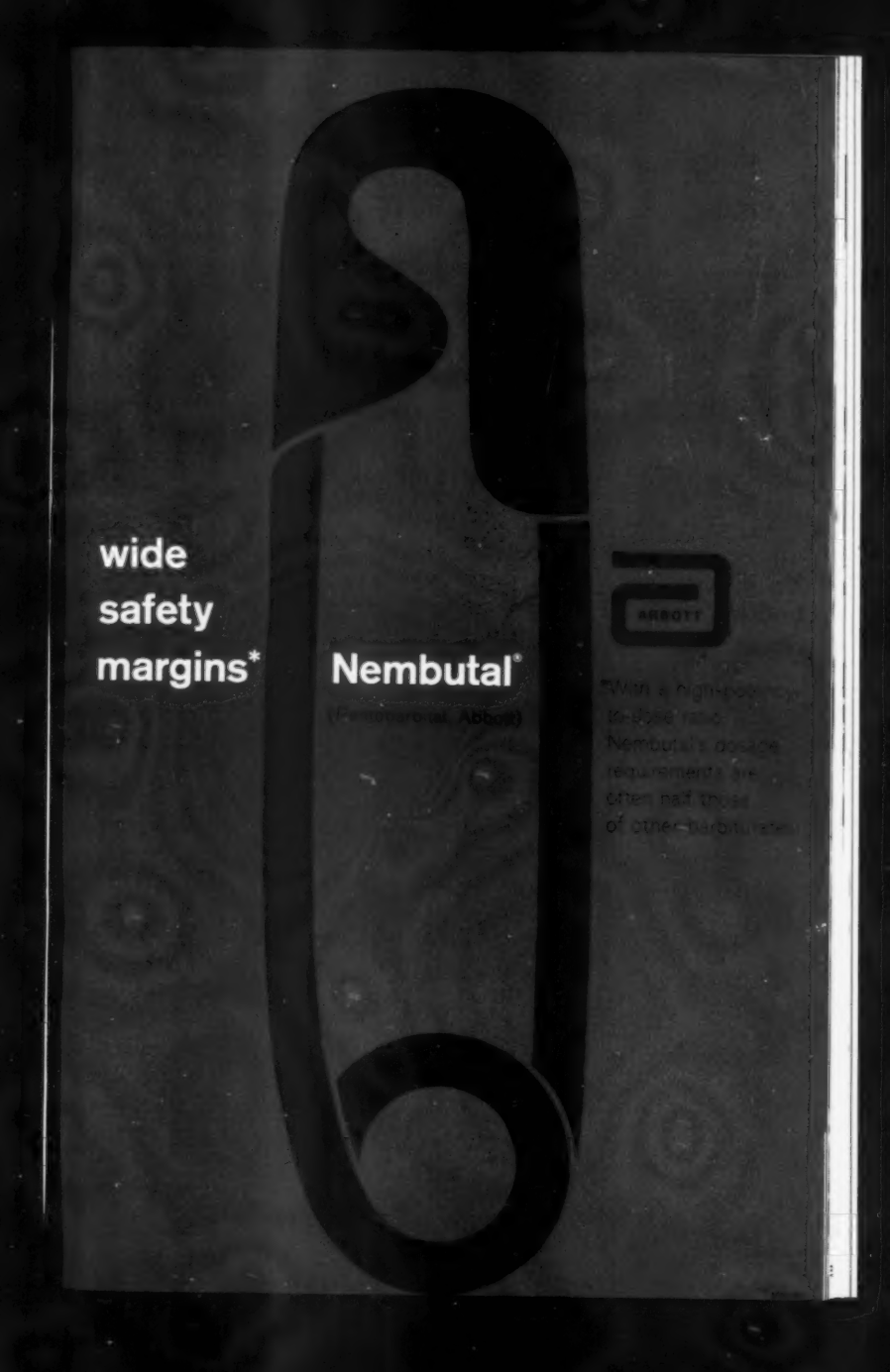
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his accountant, bank, broker, insurance agent or hospital records. The immunity is *not* available if the result of the investigation would end only in *civil liability,* no matter how onerous.

If a taxpayer surrenders his books he waives, for all practical purposes, his constitutional rights. There is no duty on the part of the agent to warn him that a possible criminal charge might be forthcoming.

Even though a taxpayer can refuse access to his records, there are disadvantages in doing so. The agent will become suspicious and redouble his energies. Failure to cooperate may be considered by a jury or the court in a later fraud case as evidencing intent to defraud.

On the other hand, many convictions in tax-evasion cases are obtained solely on information and records voluntarily presented to the investigating agents. The best advice a doctor can receive on this question is to consult a lawyer *before* turning over any records.

If the government obtains documents by the use of subterfuge, this amounts to unreasonable search and seizure, and information received will be suppressed in court. Example: the revenue agent misleads the taxpayer by claiming no criminal prosecutions will arise as a result of the investigation, while he is actually working hand in glove with a special agent from the Intelligence unit behind the scenes.

Disciplinary action

"The danger of suspension, censure, or loss of license for physicians as a result of tax problems not related to professional ethics must not be underestimated," writes a Cornell professor of law.

Professional disciplinary action for tax frauds is a new hazard, the reported court cases being of recent date. In the 1958 *Matter of the Revocation of the License to Practice Medicine and Surgery of a Washington state physician,* the supreme court of that state affirmed the medical disciplinary board's eight-month suspension of the physician's license.

The physician had pleaded guilty to filing a false and fraudulent tax return, a felony under federal law. The hearing committee of the medical disciplinary board, *without holding a hearing,* determined that the crime for which the doctor had been convicted involved moral turpitude and constituted unprofessional conduct.

The Washington supreme court

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Injection DECADRON Phosphate remains fully active for at least 2 years at room temperature.

Indications: In allergic emergencies, acute asthma, overwhelming infections (with antibiotic coverage), transfusion reactions, acute traumatic injuries. Injection DECADRON Phosphate can also be used in acute dermatoses, Addison's disease, adrenal surgery, panhypopituitarism, temporary adrenal suppression, rheumatoid arthritis, soft-tissue disorders.

NOTE: Do not inject into intervertebral joints.
CAUTION: Steroids should not be given in the presence of tuberculosis, chronic nephritis, acute psychosis, peptic ulcer, or ocular herpes simplex.

Additional information on Injection DECADRON Phosphate is available to physicians upon request.

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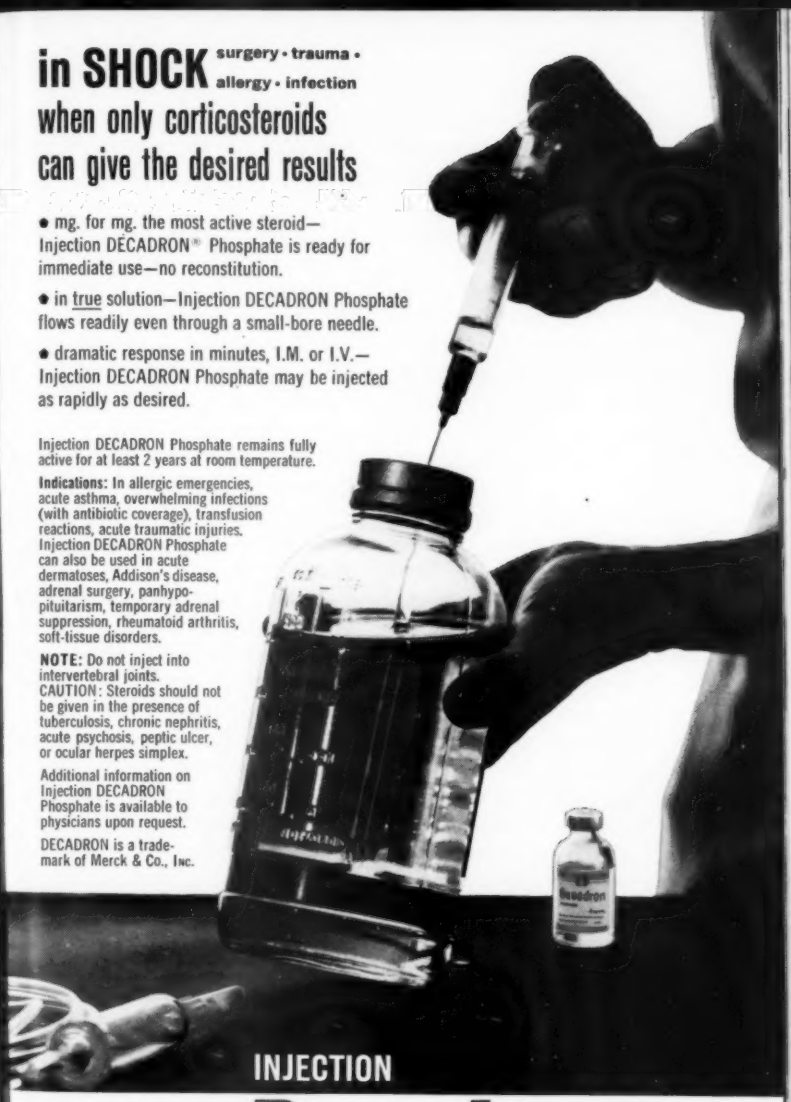

INJECTION

THE DIRECT APPROACH to corticosteroid benefits

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not only affirmed the suspension, but commented that in its opinion the disciplining of the doctor seemed mild. In contrast it noted that it had recently disbarred a lawyer for income tax fraud.

In the three-year period between 1955 and 1958 there were 25 litigated cases of physicians charged with tax fraud. In the same period there were over 500 non-court cases involving doctors in which the government asserted tax fraud.

Disciplinary action by medical boards has been widely criticized on at least two grounds. First, because the concept of tax fraud is quite technical and the line between fraud and carelessness is hard to draw. Second, it is argued that there is no rational connection between tax fraud and the ability to practice medicine.

Despite this criticism the Washington case seems to be the beginning of a new trend toward professional disciplinary action for tax fraud.

Grants, fellowships

Fees of course are taxable in the same way as any other compensation for services. *While scholarship and fellowship grants are not taxable,* all other prizes and awards are. *Gifts and bequests are not taxable.*

Frequently Internal Revenue is requested by individuals or organizations to give rulings as to whether certain items are excludable from income for tax purposes. Three such cases involved fellowship grants to doctors by the Mayo Foundation, the National Institutes of Health, and the American Heart Association.

Grants and cost-of-living allowances received by doctors from the Mayo Foundation and the Heart Association while they are studying for graduate degrees and perform no functions for the benefit of the grantor or training institution, are treated as fellowship grants and are excludable from gross income to the extent of $300 a month, for up to 36 months.

The same rule was applied to amounts received by an individual, not a candidate for a degree, under a fellowship grant for research purposes and travel expenses from the National Institutes of Health.

In the fellowships granted by the American Heart Association the Bureau ruled that the fact that progress reports are required from recipients does not destroy the essential character of the payments as fellowship grants. While payments which are really compensation for grantor-supervised

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–PLATO, *PHAEDO*

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research (research primarily for the benefit of the grantor) are not tax exempt, the Bureau ruled these fellowships to aid individuals in cardiovascular research are primarily for the training of the researcher.

In a litigated case, taxpayer was a participating physician in a graduate training program in psychiatry at a psychiatric institute. The institute served as a research and education center. Taxpayer's training included participation in the treatment of patients, as well as seminars and lectures. Degrees were not awarded, but the purpose of the training was to secure certification by the American Board of Psychiatry.

Since the primary purpose was the furthering of taxpayer's education, rather than rendering services for the institute, the stipend of $3,400 received by him qualified as a nontaxable fellowship grant.

Trips

The courts examine closely trips which combine business and pleasure. Taxpayer, a physician specializing in the treatment of alcoholism, sought to deduct $7,800 as a business expense. This was the cost of a European trip taken by him and his wife.

The trip lasted 85 days, with 56 days spent in travel between various places of interest. The court found that the many visits taxpayers made to hospitals and other health institutions in Europe were the result of natural curiosity and professional interest, and held that the trip was primarily for pleasure.

A $200 deduction was allowed as business expense. An additional deduction of $575 was allowed for the expense of mailings to doctors, patients and other business contacts. The court classified the mailing expense as "advertising expenditure."

Travel expenses to and from conventions are deductible, as well as related expenses in attending conventions. Where there are incidental personal activities such as sightseeing or social visiting, an allocation is required to be made in order to separate the deductible portion of the expenses from the nondeductible personal items.

The travel, meals, and lodging expenses of the wife are not deductible.

It is in the taxpayer's interest to keep careful records of personal and business expenses on these trips, and not rely on memory at the end of the year.

Taxpayer doctor and his wife

attended a post-convention forum cruise to Bermuda sponsored by a medical association and sought to deduct the entire cost as a business expense. The Commissioner, upheld by the court, disallowed 80 percent of the cost as a nondeductible personal expense. The doctor failed to show whether he attended any of the scientific programs provided on the cruise.

Entertainment expenses

In the examination of the returns of physicians, in some instances agents of the Revenue Service have disallowed claimed entertainment expenses as unethical. The AMA, however, has notified the Commissioner that it does not consider the incurrence of legitimate business entertainment expenses as unethical or contrary to public policy.

Cost of instruction

The expenses of an individual for his education are personal and not deductible. However educational expenses incurred to maintain and improve skills are deductible. The deductions include related travel and living expenses. Examples are the so-called "refresher" courses designed to keep the professional man abreast of developments in his field.

No deductions can be taken for expenses incurred in the study of a specialty.

An example given by a recent Internal Revenue regulation:

Dr. B., a general practitioner takes a course of study in order to become a specialist in pediatrics. Dr. C., also a general practitioner, takes a two week course reviewing developments in several specialized fields, including pediatrics, for the purpose of carrying on his general practice.

B's expenses are not deductible because the course of study qualified him for a specialty within his profession. C's expenses for his education and any transportation, meals and lodging while away from home are deductible because they were undertaken primarily to improve skills required by him in his profession.

For More on House Staff Taxes . . .

Tax Clinic: Questions and Answers . . .

House Staff Income Taxes

The inevitable is upon us—and there is wailing in the land. But don't panic. Before completing your federal income tax return, check these important suggestions concerning resident and intern tax liability. The dollar you save will be your own!

Joseph Arkin, CPA

Let's face it, the Federal Income Tax return is a grim monster. It's like a final exam—with an entire year's grade riding on the result. A few of the reasons for this are obvious:

- It's not fun
- It costs money
- It has to do with arithmetic
- Only lawyers and accountants can understand it
- The kitchen table is never quite large enough to hold all the instructions, records, slips of paper, computations, coffee etc., required to complete the form.
- You have to sign it and swear you've been strictly on the level.
- Your wife has to sign it—and that just doesn't seem right since you can't picture her enjoying penitentiary life.
- It's *definitely* not fun.

Yet, there is usually one consolation. It will be easier this year than next.

As a resident or intern, there are a number of expenditures you have made during the year which are necessary to your professional employment or personal needs—

reverse hypovolemic shock quickly, economically

without the dangers of blood transfusion

An estimated 3,000 patients die each year as the result of blood transfusion reactions.[1] When hypovolemic shock is treated with ALBUMISOL®, most of the risks inherent in blood transfusion are bypassed. With ALBUMISOL, there is— **■ no danger of hepatitis ■ no waiting or expense for typing, cross-matching, or grouping.**

Most importantly, ALBUMISOL is the protein responsible for 80 per cent of the colloid osmotic pressure of plasma. It therefore fills the most urgent need in hypovolemic shock—restoration of pressure.

ALBUMISOL 25% (salt poor) is also available to help you manage nutritional deficiencies and severe fluid retention of advanced cirrhosis and nephrosis. Increased production now makes possible new lower prices on both products.

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ready for immediate blood volume replacement

SUPPLIED: ALBUMISOL 5% in 250-cc. and 500-cc. bottles.
ALBUMISOL 25% (salt poor) in 20-cc. and 50-cc. bottles.

1. Hirsh, B. D.: Medicolegal Digest, 1:21, June, 1960.

Additional information is available to the physician on request.

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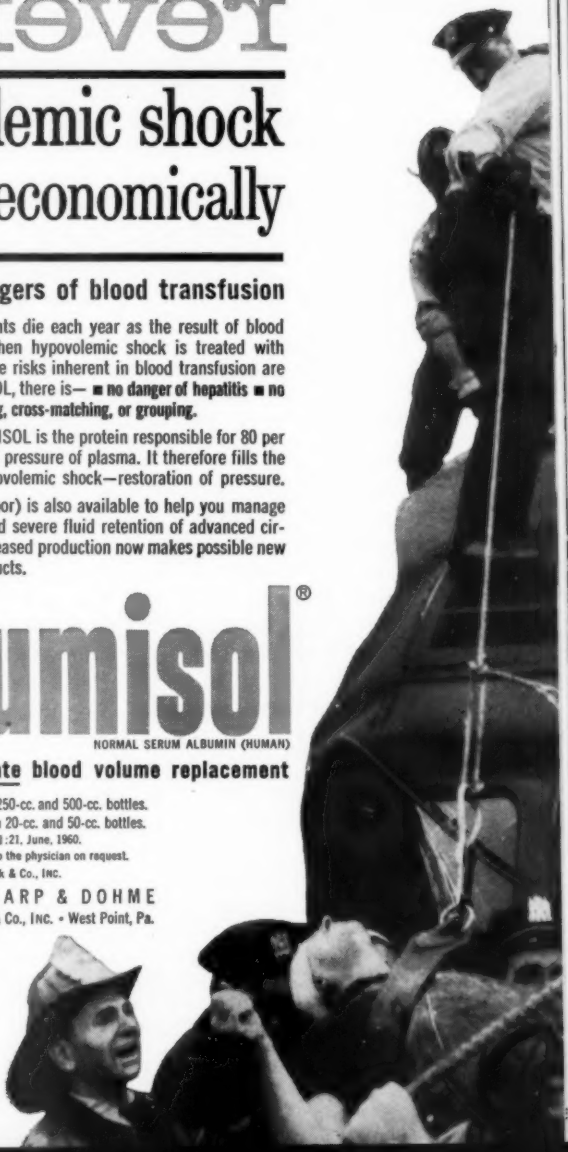

expenditures which should be given consideration when preparing your return. For example, dues to medical societies, licensure fees, malpractice insurance premiums (Form 1040 only, under "Miscellaneous" on page 2), and many others.

There are also the usual *personal* expenses you have incurred during the year, some of which are allowable as deductions. Let's whip through this latter category first.

Standard deduction

The tax regulations provide for many allowable personal deductions. These are described in the explanation sheet accompanying your tax forms and need no discussion in this article.

However, the Internal Revenue Code also permits an overall deduction called "standard deduction" of 10% of the adjusted gross income, *in lieu of all other personal expenses,* with a ceiling of $1,000. Thus, an option is extended to all taxpayers whether salaried or self-employed. By making a list of allowable personal deductions, you can readily determine whether or not to take the standard deduction or to itemize. Regardless of which choice is made with regard to *personal* expenses, you will also be permitted to itemize allowable *business* expenses which are deductible.

Business

If you are in your last year in hospital training and are preparing to enter practice in July, there are other items which bear some relationship to establishing your practice and securing patients which may be considered deductible. Entertainment which results in a direct effect on the success of your practice, and travel costs which are necessary to establish your practice, under certain conditions may be allowed as deductible from your "adjusted gross income" (see tax form) before computing your actual tax.

ABOUT THE AUTHOR Mr. Arkin received his degree in Accounting from St. John's University in 1944, his certificate as Certified Public Accountant from New York State in 1947, and is enrolled to practice before the Treasury Department. He has written many articles on taxation, investment, business and finance, four of them appearing in previous issues of RESIDENT PHYSICIAN.

Lifts depression...as it calms anxiety

Smooth, balanced action brightens mood, restores normal sleep...rapidly and safely

Balances the mood—no "seesaw" effect of amphetamine-barbiturates and energizers

Acts swiftly—the patient soon returns to her normal activities

Acts safely—no danger of liver or blood damage

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

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Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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Another expense applicable to all interns and residents — your medical library. May you annually deduct a portion of your cost (known as depreciation) on your tax return? Yes, but it isn't always wise. Although a deduction for depreciation of your medical books can be taken during the period of internship or residency, the tax benefits to be derived would be relatively small compared to those realized if this deduction were deferred to a later period, taking the deduction when you are in a higher tax bracket. This rule of thumb would apply as well to any medical equipment acquired during the period of internship or residency *if the value of the equipment is relatively stable,* such as with an EKG. (It must be stable, since you must value the item at current market value at the time you take the depreciation deduction.)

The individual must decide which is more important, an immediate saving in a low bracket tax or a deferred saving in a higher bracket.

Car depreciation

Now, what about the depreciation on your automobile? Since you use your automobile almost exclusively to travel between home and hospital (rather than using the automobile for the benefit of the hospital), you cannot deduct its depreciation. The Internal Revenue Code specifically states that no automobile expenses may be deducted for "travel to and from work."

The beginning practitioner, however, may reflect auto expenses on his tax return. In such an instance, the physician should start deducting depreciation *immediately.*

This principle can be emphasized by an analysis of the distinction in classification between the automobile and all other capital assets of the doctor. The most significant difference is the relatively *fast rate of obsolescence* inherent in the use and ownership of a car. (Other applicable assets will probably carry a useful life three or four times that of the automobile.)

One further word regarding depreciation. Although numerous methods of calculating depreciation exist, the method best-suited

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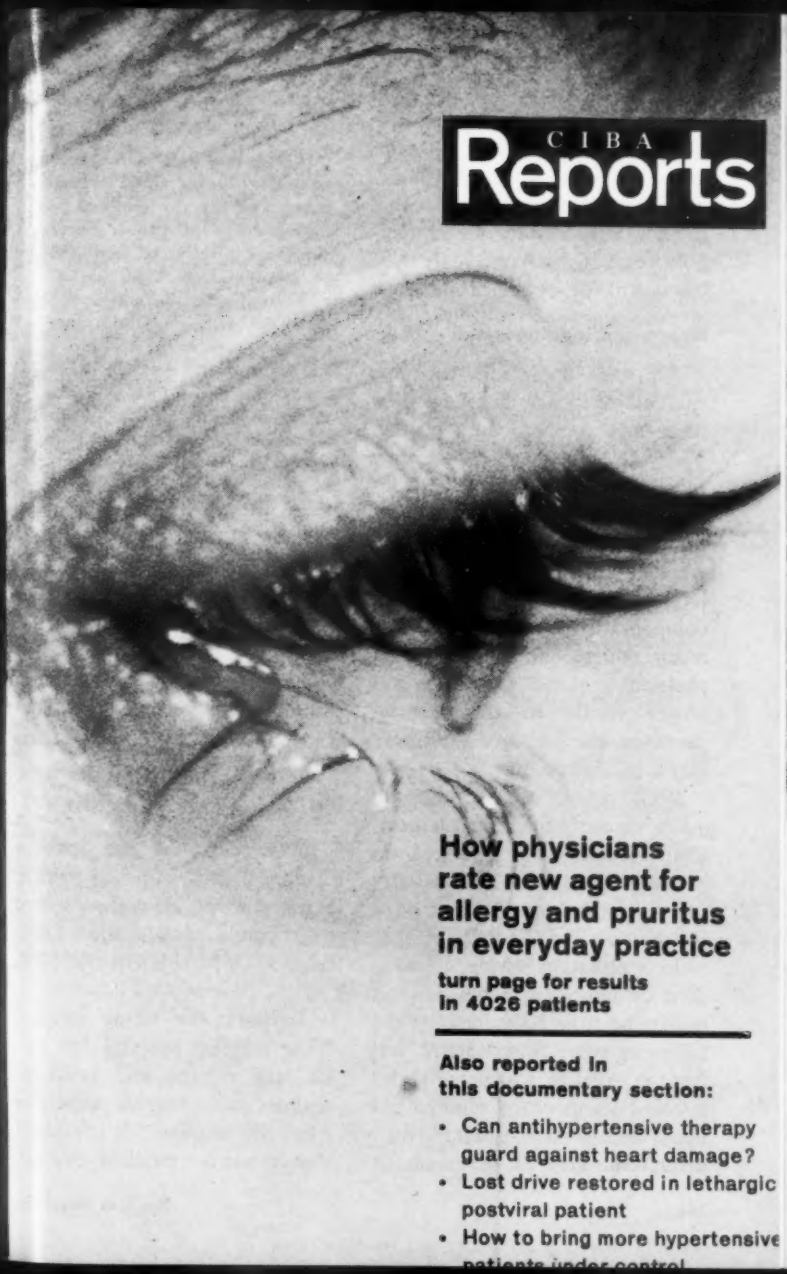
RESIDENT PHYSICIAN suggests that you use the information in this article in conjunction with your accountant or lawyer. Your letters are welcome and should be addressed to Joseph Arkin, C.P.A. c/o Resident Physician, 1447 Northern Boulevard, Manhasset, N. Y.


CIBA
Reports
How physicians rate new agent for allergy and pruritus in everyday practice
turn page for results in 4026 patients
Also reported in this documentary section:
• Can antihypertensive therapy guard against heart damage?
• Lost drive restored in lethargic postviral patient
• How to bring more hypertensive

to long range tax savings for the beginning practitioner is the method known as "straight-line." The basis of depreciation in this method is to divide the depreciable value of the asset *evenly* over the useful life of the property.

Board and lodging

An area applicable to most salaried residents and interns is in regard to board and lodging. The value of meals or lodging furnished an intern or resident for "the convenience of the hospital" is not taxable income, whether or not the meals and lodging are provided as a part of compensation. With regard to meals, where the nature of the position requires that the employee reside on the hospital premises, the value of the meals is not taxable income.

With regard to lodging, the value thereof, may be excluded from taxable income *only if the employee must accept the lodging on the hospital's premises as a condition of his employment.*

In a situation where the resident or intern must pay for his meals, he may be guided by the following rule: an employee, unless the expense is incurred under a reimbursement or similar expense arrangement, generally may deduct the cost of his meals as an expense if he can show that the expenditure is required by his employment agreement or is incident to the performance of his duties.

HEAVY SCRUTINY

The Internal Revenue Service is well aware of the fact that a portion of the professional business income of physicians and surgeons is reflected in the flow of monies on a "cash basis."

Recognizing the inherent deficiencies of this method, from a control standpoint, the tax department earmarks MDs' tax returns for extra heavy scrutiny, frequent audits, and rigid specifications for norms and estimated expenses.

Physicians are advised to take care with their record-keeping and reporting of income and expenses.

Stipends

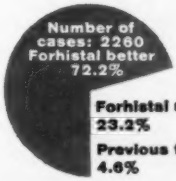
In a ruling by the Internal Revenue Board, stipends paid to interns and residents were held to be taxable compensation. (Rev. Rul. 57-386, I.R.B. 1957-35, 10.)

In part, the ruling states: "The training hospital has on its staff interns and resident doctors who receive stipends from the hospital. It is stated that modern medical educa-

Allergy and pruritus treated with new Forhistal®... a report on 4026 cases

Following initial clinical investigational work, Forhistal was sent to physicians throughout the country for evaluation as an antiallergic and antipruritic agent in everyday practice. Results in 4026 cases reported have now been analyzed. In 2260 cases a comparison was made between Forhistal and previous therapy. Results are shown below. Information about the investigational work done previously is being mailed to you and is also available on request.

Compared with previous therapy
Forhistal rated better in 7 out of 10 cases of allergy and/or pruritus

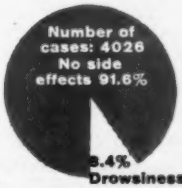


Response to treatment in allergic and/or pruritic disorders
Marked to moderate relief in more than 8 out of 10 cases

Forhistal brings marked to moderate relief of allergic and/or pruritic symptoms in 3422 out of 4026 patients

Diagnoses	No. of Cases	RELIEF		
		Marked to Moderate	Slight	None
Respiratory Allergies	2130	1805 (84.7%)	195 (9.2%)	130 (6.1%)
Allergic Dermatoses	1296	1111 (85.7%)	106 (8.2%)	79 (6.1%)
Pruritus	533	456 (85.6%)	50 (9.3%)	27 (5.1%)
Miscellaneous	67	50 (74.6%)	8 (11.9%)	9 (13.5%)
Totals	4026	3422 (85%)	359 (8.9%)	245 (6.1%)

Side effects
None reported in 9 out of 10 cases



See the Therapeutic Guide at the end of this documentary section for complete information about indications, dosage, precautions, and side effects of Forhistal.

2/2906HK

tion requires training beyond that provided by four years at a medical college. This additional medical education is provided by supervised general experience and training in hospitals. Such training is obtained by service of an internship. If on completion, the doctor desires to specialize in a particular field of medicine, it is necessary to serve a 'residency' under qualified supervision.

"The interns and resident doctors are appointed periodically and receive stipends from the hospital and some receive room and board. In the course of and as part of their training, all assist in the care of patients at the hospital.

"Section 1.117-4 (c) of the Income Tax Regulations provides, in part, that if any amount paid or allowed to be on behalf of an individual, to enable him to pursue studies or research, represents compensation for past, present, or future employment services, or represents either payment for

services which are subject to the direction or supervision of the grantor or research primarily for the benefit of the grantor, such payments or allowances shall not be considered as amounts received as a scholarship or a fellowship grant for the purpose of section 117 of the Code.

"The interns and residents in the instant case are primarily performing services for the hospital as physicians, even though, in the process, they are acquiring training and experience in their particular specialties. The stipends received under such circumstances represent compensation for services and do not constitute scholarships or fellowship grants within the meaning of section 117 of the Internal Revenue Code of 1954. Accordingly, such compensation is includible in gross income under section 61 (a) of the Code." (See page 124 for fellowships, etc.)

Tax Q & A
NEXT PAGE ▶

Report

Hypertension of over 12 years relieved with Esidrix®

With Esidrix, Mr. S. was able to conduct his business activities and enjoy his customary fishing trips without discomfort or apprehension.

H. S., a 48-year-old salesman, had been suffering from labile hypertension for over 12 years. Both phenobarbital and rauwolfia had failed to stabilize his blood pressure. Reserpine and chlorothiazide brought some control, but side effects were troublesome. On May 5, 1959, feeling unusually tense, nauseated and dizzy, Mr. H. S. visited his physician.

Work-up disclosed blood pressure of 210/120 mm. Hg, a trace of pretibial edema, heart slightly enlarged to the left, coronal headache, normal urinary function and blood chemistry, and essentially normal EKG. The physician prescribed Esidrix (to be taken with orange juice), and recommended continuation of unrestricted salt diet.

Blood pressure of 210/120 reduced to 140/90 with Esidrix

Date	Therapy	Blood Pressure (mm. Hg)	Observations
5/5/59	Esidrix (taken with orange juice)	210/120	Dizzy, headache.
5/15/59	Esidrix (salt added to diet)	210/120	Muscle cramps.
5/22/59	Esidrix	160/90	Patient greatly improved.
6/5/59	Esidrix	148/90	Improvement maintained. Headaches, dizziness, nausea gone.
6/19/59	Esidrix	140/90	
6/26/59	Esidrix (KCl substituted for orange juice because of gastric distress)	140/90	Patient feels well, but somewhat weak.
7/3/59	Esidrix	140/90	Patient no longer weak; continues to feel well.

Esidrix® for edema and hypertension
(hydrochlorothiazide CIBA)

Photos used with permission of the patient.

Q and A

Q. **"I plan to enter private practice and will incur expenses to investigate possible locations. These items will include travel to other cities, hotel and lodging, carfares, etc. Can I deduct these expenses on my federal income tax return?"**

A. It is quite true that many doctors who plan to *purchase* a practice will travel to the site to examine the physical premises. Expenses will also be incurred for an accountant to check the books and for a lawyer to negotiate terms of purchase. The same holds true for the doctor looking for a suitable location within which to *establish* his practice.

Generally speaking you cannot get a deduction for such expenses if you do no more than merely investigate. If you settle in a location and operate a practice for a short time,

and then abandon it because you find it unsuitable you can get a deduction because you did more than merely investigate (Parker, 1 Tax Court 709 (acq.).

However, suppose you just spend time and money chasing around the country looking for a suitable spot to buy or establish a practice. Because you enter into no actual business the courts will probably disallow your "exploratory" expenses (Frank, 20 Tax Court 511; Polachek, 22 Tax Court 858). This rule even applies to an established doctor who incurs such expenses after abandoning one practice and is in the search of another location in which to reopen his practice (Day, Tax Court Memo 1956–253).

Q. What are the rules in connection with the deductibility of malpractice insurance premiums?

A. The Treasury Department has taken cognizance of the fact that there are a great number of malpractice suits directed

against physicians. (The AMA reports that 6,000 doctors were sued in 1959, with damage and out-of-court settlements amounting to an estimated $50 million.)

The self-employed physician can deduct this type of insurance coverage under the provisions of Section 162 (a) of the Internal Revenue Code of 1954 which states in part, as follows:

> (a) In General — There shall be allowed as a deduction all the ordinary and necessary expenses paid or incurred during the taxable year in carrying on any trade or business. . . .

Inasmuch as this coverage has become accepted as "ordinary" and "necessary" (95% of all U. S. doctors carry such insurance) the self-employed doctor can deduct this expense from his total receipts to arrive at the net income from his practice.

On the other hand, the employed physician must handle his expense for malpractice insurance in another fashion. The malpractice insurance premiums paid by a physician who is an employee, carried in order to protect himself against suits

arising as a result of his performing duties as an employee, are also considered to be appropriate and helpful to his business. However, Section 1.62–1 of the Income Tax Regulations provides in effect that expenses of an employee (with certain exceptions not here material) are not deductible from a taxpayer's adjusted gross income.

The deduction for this expense can be taken only if the physician elects to itemize his deductions — and in that event the expense for malpractice insurance is deducted under the heading "Miscellaneous" on page two of Form 1040. Where the physician uses the tax table or the standard deduction (10%), no deduction can be taken for the malpractice insurance premium expense. (Revenue Ruling 6-365, Internal Revenue Bulletin, 1960-49, page 7.)

Q. I work in a hospital as a resident physician. On occasion patients pay their bills by check payable to my order, which I in

Reports Therapeutic Guide

DORIDEN® (glutethimide CIBA)
Nonbarbiturate Daytime and Night-time Sedative

Indications and dosage: *Night-time Sedation:* 0.5 Gm. at bedtime. May be taken again when needed but not less than 4 hours before rising. *Daytime Sedation:* 0.125 to 0.25 Gm. t.i.d. after meals. *Preoperative Sedation:* 0.5 Gm. the night before surgery; 0.5 to 1 Gm. 1 hour before anesthesia. *First Stage of Labor:* 0.5 Gm. at onset of labor. May be repeated if needed.

Caution: As with other sedatives, emotionally disturbed patients who may receive Doriden over prolonged periods should be observed carefully for possible signs of dependence, even though this occurs only rarely. To minimize withdrawal reactions, dosage should be reduced gradually.

Side effects: Side effects are minimal. Skin rash may occur occasionally, in which case Doriden should be withdrawn.

Supplied: *Tablets,* 0.25 Gm. (white, scored) and 0.5 Gm. (white, scored); bottles of 100, 500 and 1000. *Tablets,* 0.125 Gm. (white); bottles of 100.

FORHISTAL® maleate
(dimethpyrindene maleate CIBA)
A New Agent for Allergy and Pruritus

Description: Forhistal is a new, low-dosage antiallergic and antipruritic agent which relieves symptoms in a wide range of allergic and pruritic disorders. Forhistal, as clinical evidence shows, is well tolerated in patients of all ages.

Indications: *Respiratory allergies:* seasonal and perennial rhinitis, vasomotor rhinitis, bronchial asthma, etc. *Ocular allergies,* especially those accompanying hay fever. *Allergic dermatoses:* urticaria, angioneurotic edema, dermatitis medicamentosa. *Pruritic dermatoses:* for relief of itching, as an adjunct to other therapy in management of atopic and contact dermatitis, etc.

Average dosage: Adults and children over 6 years of age: *Lontabs*—1 Lontab once or twice daily. *Tablets*—1 or 2 tablets 1 to 3 times daily. *Syrup*—1 or 2 teaspoons 1 to 3 times daily. Children under 6 years of age: *Pediatric Drops*—0.25 mg. (0.3 ml.) to 0.5 mg. (0.6 ml.) 2 or 3 times daily.

Side effects: The principal side effect reported is some degree of sedation or drowsiness. Other side effects, which have occurred infrequently, are dryness of mouth, gastrointestinal discomfort, nausea or diarrhea, excessive stimulation, insomnia or irritability, dizziness, headache, bladder discomfort and increased nocturia.

Supplied: *Lontabs,* 2.5 mg. (orange); bottles of 100. *Tablets,* 1 mg. (pale orange, scored); bottles of 100. *Syrup* (pink), containing 1 mg. Forhistal maleate per 5-ml. teaspoon; bottles of 4 fluidounces. *Pediatric Drops* (pink), containing 0.5 mg. Forhistal maleate per 0.6 ml.; bottles of 1 fluidounce, with droppers calibrated for delivery of 0.3 or 0.6 ml.
LONTABS® (long-acting tablets CIBA)

RITALIN® hydrochloride
(methylphenidate hydrochloride CIBA)
Stimulant-Antidepressant

Indications and dosage for oral Ritalin: Whenever lethargy is a problem—as in menopause, senility, oversedation, mild depression, and convalescence—Ritalin safely restores physical and mental activity within normal physiologic limits. Dosage depends upon indication and individual response. Many patients respond to 10 mg. b.i.d. or t.i.d. Others may require 20-mg. doses; in a few cases, 5-mg. doses will be adequate.
Contraindication: Agitated depression. However, patients in this state have responded very well to a combination of Serpasil and Ritalin, since optimal doses of both drugs can be given with fewer side effects.

Side effects: Side effects have usually been minimal. Among complaints mentioned have been nervousness, insomnia, and a few cases of anorexia, nausea, dizziness, palpitation, headache, and drowsiness. Very rarely blood pressure and pulse changes, both up and down, have been recorded. A small number of patients, particularly those with an element of agitation, may react adversely to Ritalin; in these cases medication should be discontinued.

Supplied: *Tablets,* 5 mg. (yellow) and 10 mg. (light blue); bottles of 100, 500 and 1000. *Tablets,* 20 mg. (peach-colored); bottles of 100 and 1000.

Information on the use of parenteral Ritalin (indications, dosage, cautions, and side effects) sent on request.

SERPASIL® (reserpine CIBA)
Antihypertensive and Heart-Protecting Agent

Indications and dosage: Serpasil reduces blood pressure in patients with mild to moderate hypertension. It is especially useful in anxious, tense patients, and in those with tachycardia—for it exerts a calming effect, imparts a sense of well-being, and tends to normalize the heart rate. In addition, Serpasil depletes catecholamines from the heart; it may thereby protect hypertensive patients against catecholamine-induced heart damage.

(turn page)

2/2904MK

Serpasil may be used alone or in combination with other antihypertensive agents. In the average patient not receiving other antihypertensives, the average initial dose is two 0.25-mg. tablets daily, with a range of 0.1 to 1 mg. Continue for at least a week. If results prove satisfactory—as they will in many cases—no other medication is necessary. For maintenance, the dose should be reduced to 0.25 mg. or less daily. If the response to Serpasil alone is inadequate, other agents such as Esidrix, Apresoline, or Ismelin may be added to the regimen.

Caution: During anesthesia, significant hypotension and bradycardia have been observed in hypertensive patients being treated with Serpasil. If possible, Serpasil should be withdrawn from such patients 2 weeks prior to elective surgery. If an emergency operation is required, vagal blocking agents should be given parenterally to prevent or reverse hypotension and/or bradycardia.

Because Serpasil may increase gastric secretion, it should be used with caution in patients with a history of peptic ulcer.

Side effects: The side effects of Serpasil are characteristic of all rauwolfia preparations. Because of its sedative action, some patients may experience lassitude or mild drowsiness, especially during the period when the dosage is being adjusted. This usually disappears when the optimal dosage level has been attained. Nasal stuffiness or congestion of varying degree occurs occasionally and may be alleviated by use of a suitable topical vasoconstrictor. Increased frequency of defecation and/or a tendency to looseness of stools may occur occasionally. Other side effects, rarely observed, include anorexia, headache, nausea, and dizziness.

A very few patients taking Serpasil have developed moderate to severe "depression." When the drug is discontinued, depression usually disappears, but active treatment including hospitalization for shock therapy has been required in some cases. Adjunctive use of mood-elevating agents such as Ritalin is often sufficient to relieve *mild* depression.

In general, it is preferable to administer Serpasil after meals in order to obviate the discomfort due to possibly increased gastric secretion.

Supplied: *Tablets,* 0.1 mg. (white), 0.25 mg. (white, scored) and 1 mg. (white, scored); bottles of 100, 500, 1000 and 5000.

Information on the use of parenteral Serpasil (indications, dosage, cautions, and side effects) sent on request.

SINGOSERP® (syrosingopine CIBA)
Lowers Blood Pressure—Usually Without Rauwolfia Side Effects

Indications and dosage: For mild to moderate hypertension, including pre-eclampsia and essential hypertension associated with pregnancy. The suggested initial dose is 1 to 2 tablets (1 to 2 mg.) daily in single or divided doses. Some patients may require and will tolerate 3 or more tablets daily. Since Singoserp has both a gradual onset and prolonged duration of effect, a trial of at least 2 weeks with the starting dose is indicated for the proper evaluation of results. The dose for long-term maintenance therapy in most cases will range from ½ to 3 tablets (0.5 to 3 mg.) daily. In more resistant cases, Esidrix, Apresoline, or Ismelin may be used in combination with Singoserp—in lower dosages than when they are used alone.

Caution: Since rauwolfia preparations are known to stimulate the secretion of gastric fluids, caution should be exercised in administering Singoserp to patients with peptic ulcer and to those with histories suggestive of this disorder.

Marked hypotension has been reported in patients undergoing anesthesia while being treated with conventional rauwolfia drugs. Therefore, it may be desirable to reduce or discontinue the dosage of Singoserp several weeks prior to an elective procedure.

Side effects: The side effects of Singoserp are less frequent and milder than those of conventional rauwolfia drugs. Nasal congestion, usually mild, occurs occasionally and may be relieved by use of a suitable topical vasoconstrictor. Other side effects which occur even less frequently are gastric irritation, drowsiness, fatigue, nausea, headache, emotional depression, skin rash, restlessness, and anxiety.

Reports of emotional depression associated with the use of Singoserp have been rare and therefore difficult to interpret. Moreover, a number of patients manifesting symptoms of depression during treatment with conventional rauwolfia drugs either have not had a recurrence of these symptoms or have actually experienced relief of them when given Singoserp in doses producing adequate control of blood pressure.

Supplied: *Tablets,* 1 mg. (white, scored); bottles of 100 and 1000.

Complete information about dosage, precautions, and side effects for ESIDRIX and SER-AP-ES will be sent on request. 2/2903MR

turn endorse over to the hospital. Are these fees includible in my gross income? What is their status under present regulations or laws?

A. This situation arises where physicians are appointed on a full time basis to the staff of a hospital. The terms of employment usually provide that such physicians shall not receive any fees or compensation for his individual benefits from or on behalf of any patients admitted or treated at the hospital.

It has been held by the Treasury Department where, under the outlined circumstances, checks are received by a physician and are immediately endorsed to the hospital, the physician is not required to include the amounts thereof in his gross income. He is merely an agent for the hospital, acting as a conduit for the fees collected.

It would seem to follow that this rule would apply to fees collected by doctors in private practice in a situation where the payment to the doctor is in the form of checks (from insurance companies, medical health plans, etc.) which are in fact reimbursement to the patient, but made payable to the doctor.

The Internal Revenue Service advises that a doctor receiving fees under such conditions should attach to his Federal income tax return a schedule setting forth the sources of the fees, the amounts received and the disposition made of them. (Revenue Ruling 58-220, I.R.B. 1958-20, page 8.)

Q. I am under contract as a surgeon to the Department of the Army, not a member of the Armed Forces, and receive subsistence and rental allowances in cash in addition to the contract salary. Are these items includible in gross income and subject to withholding tax provisions?

A. Section 61 of the Internal Revenue Code provides, with certain exceptions that gross income means all income from whatever source derived. In Income Tax Regulations 1.61-2 there is a provision that subsistence and uniform allowances granted commissioned officers or enlisted personnel are excluded from gross income. Similarly, the value of quarters or subsistence furnished to such persons is also excludible from gross income.

The old (1925) Clifford Jones decision is the basis for these regulations, but in Gunnar Van Rosen 17 Tax Court 834, it

was held that the Clifford Jones decision did not apply to a civilian shipmaster employed by the Army Transportation Corps.

Because you are not a member of the uniformed services and are in fact a civilian employee (under contract) the cash allowances for subsistence constitute wages and are includible in gross income and also are subject to the withholding of income tax at source. (Revenue Ruling 60-66 C.B. 1960-1, page 21.)

National Guard officers should note that for the purpose of section 1.61-2 quoted above, the National Guard is considered to be part of the Armed Forces of the United States. Accordingly, the value of quarters and subsistence, or an allowance received in commutation thereof, furnished to National Guard officers and enlisted personnel while on active duty, is not includible in the gross income of the recipients.

Q. I am receiving funds from the American Cancer Society as a grant for specialized training in the study of cancer. What is the latest ruling on this grant as to inclusion or exclusion from gross income?

A. Grants for Scholars in Cancer Research made by the American Cancer Society through certain institutions as administrators, which are paid to specified individuals to aid them to acquire independent experience in cancer research beyond that usually obtained through postdoctoral training, constitute fellowship grants which are excludable from the recipients' gross incomes to the extent provided by Section 117 (b) (2) of the Internal Revenue Code of 1954. Furthermore, since the recipients render no services to or for the benefit of the grantor or the institution administering the grants, such amounts do not constitute wages subject to the withholding of income tax under section 3402 of the Code. (Revenue Ruling 60-130, C.B. 1960-1, page 46.) *Also see page 124 in this issue of your journal.*

How to Equip the Ophthalmology Office

Space arrangement is particularly important to the ophthalmologist. Here's what a survey of practitioners in the field reveals about office equipment needs in the specialty.

"In setting up an eye office, the first thing the prospective ophthalmologist should do is decide on the number of rooms and their layout."

This was one of the comments made by practicing ophthalmologists in response to a RESIDENT PHYSICIAN survey on equipping specialty practices. Most emphasized the importance of the arrangement and size of rooms.

In figuring space requirements, the first consideration, according to eye specialists, should be in establishing a 20-foot examining distance for testing visual acuity. This actually means a floor dimension something in excess of 20 feet. And locating such a room is in itself no small problem.

Some respondents mentioned modifications which permit the use of a less than 20-foot examining distance. "But these," according to one, "usually lend confusion to an examination where relaxation of the patient is important."

Other necessary space includes a waiting room, reception room, examining room and perhaps a dark room where many of your

basic examinations can be made. However, some ophthalmologists note that if a large amount of space is not available, the latter three rooms can be combined into a single room.

If a separate dark room is decided upon, it should be painted dark gray or black.

"Only a few simple wall lights or a dim ceiling light should be installed; many eye examinations are purposely accomplished without external illumination, using only the illumination with which the various instruments themselves are equipped," reports one ophthalmologist. Most respondents mentioned this point. One said he had installed a variable lighting switch (rheostat) control by which "any degree of light can be obtained."

Eye specialists agreed the reception room should be simply furnished, "without too many embellishments;" and it should be free of shiny, light-reflecting surfaces, "discomforting to a patient coming in for an eye examination."

Office furniture recommendations touched upon most of the usual types seen in the average medical or surgical office.

"Probably, conservative wooden type furniture is best because it is more dignified in appearance," said one. "Less brassy looking than the average metallic furniture and also not so glary."

This "glare" business is important. One respondent reported: "Glare is strictly to be avoided. It interferes with the examination and is distracting and annoying to the patient undergoing the examination."

However, even though the purchase of office furniture should be directed towards "simple, tasteful, subdued and non-glary"

Office equipment you'll need in private practice

This is the seventh in a series of exclusive articles on equipping your office for the private practice of your specialty. It is based solely on a survey conducted by your journal among practicing specialists.

Prices quoted are approximate and represent new equipment unless stated to the contrary. When a wide range of price and quality is available for a specific item, this fact is indicated.

pieces, many ophthalmologists indicated that coarse-textured plastic, leather, and upholstered furniture would fill the bill. These pieces of furniture, depending on the materials used, range between $50 and $70 each.

First consideration

The ophthalmologist acquires an ophthalmoscope ($50) in medical school, and a retinascope ($40) later on. Usually, he has a binocular eyeloop (either a head type or one that fastens on his glasses or behind his ears) and one or more pocket lights. Thus, first consideration will be directed towards the purchase of the bulkier items of specialized office equipment.

New equipment

Should the prospective ophthalmic surgeon purchase new or used equipment? "Eye equipment," one doctor stated, "if handled with care, can be made to last a lifetime." Said another: "You never can be certain that used equipment will be serviceable. And since all eye examinations must be carried out with meticulous care, only that equipment which lends itself to producing perfection should be purchased."

Of the minority, most agreed new equipment was better, " . . . but sometimes you just don't have an alternative because of cost."

The first pieces of equipment to consider are the specialized eye chair, the trial lens set, lens cabinet, testing charts, and the trial-frame for mounting testing lenses on the patient.

In addition to these, a number of items of equipment are essential to the refraction examination.

Refractometers

Most specialists use the lens set with a multitude of individual, vari-sized lenses, prisms, and special lenses. However, refractometers are available with lenses which can be swung into place before the patient's eyes. While these are "compact and very convenient," according to some eye specialists, others hold them to be "expensive and bulky."

Before purchasing, the prospective surgeon should be certain, say many respondents, that sufficient office space is available for a refractometer. Careful measurement of space and equipment is necessary. Refractometers with mounted lenses can be bought from $800 to $1000.

Eye testing charts are available in the form of cards, illuminated boxes, and as slides projected on a screen. The latter are "excel-

NEW INHIBITOR OF GASTRIC ACID SECRETION

NACTON®

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- suppresses gastric acid secretion at the parietal cell level
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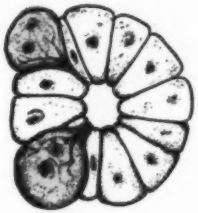
NACTON®...Has been shown to suppress gastric acid secretion for as long as 8 to 9 hours.[1] "...reduces the total output of gastric HCl by about 60%."[2] Decreases hypermotility of stomach and bowel.[3-7] Aids healing of peptic ulcer.[8] Unusually low incidence of side effects.[1,3,9]



Available as:
Tablets Nacton 4 mg.

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McNEIL

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lent" according to the majority of ophthalmologists responding, "from the point of view of convenience and maneuverability."

The reading test charts, especially calibrated for the near distances, can be purchased or can usually be obtained gratis from the optical equipment manufacturer or retailer.

Trial frames (around $75) come in a variety of forms (and prices). During his residency the eye man has a chance to use many types and can usually get an idea of which suits him best.

Lens racks

Lens racks are convenient accessories for determining quickly a rough estimate of the refractive error. These racks hold a graduated series of lenses in the minus and plus strengths with which the basic refraction can be quickly assessed before going on to further refinement. These can be purchased for about $25. In addition a set of cross cylinders will speed and abet the accuracy of the examination.

Testing color vision, although done by many methods, can be accomplished by the pseudo-isochromatic charts. These charts can be purchased from a number of sources. Prices vary from $15 to $25.

Three other pieces of office equipment are considered basically essential to the eye practitioner. These are the slit lamp (cost from $450 to more than $1000), the lensometer ($350-$500), and the perimeter ($250-$300). Incidentally, these and other optical pieces are available in both U.S. and foreign manufacture. When dealing in foreign made equipment, reliability of the manufacturer and availability of service and parts are especially important factors, according to the panel.

Orthoptic

Other instruments available to the ophthalmologist, and employed by many in their practices, come under the heading of orthoptic instruments; used in the study and training of eye deviations due to defects, weaknesses, or other involvements of the extra-ocular muscles.

This equipment usually requires a full-time assistant, an orthoptic technician, otherwise, the doctor must set aside a large portion of his own time for using these instruments. However, in the beginning practice, chiefly because of "time plus the added cost of trained assistants," according to respondents, the purchase of orthoptic instruments seldom proves to be "a good *early* investment."

Yet, most ophthalmologists agree that some simple orthoptic instruments, such as a stereoscope ($10) and a set of cards, do have ready use.

"The doctor can use these for quick evaluation of muscle deviation and as an instrument of instruction to the parent whose child has a low grade muscle error." Incidentally, the specialist should have a separate box of prisms with which to measure muscle deviation. In this examination he will be aided by the special lenses found in every lens testing set.

Other equipment

Another instrument which members of the panel termed necessary is the ophthalmometer ($425), valuable in measuring the corneal surface and of some use in measuring the astigmatic area in difficult cases of refraction. However, some ophthalmologists indicated that other measuring methods were adequate for the needs of the beginning specialist.

TO AVOID MISTAKES:

1. Consult an office equipment company which maintains an advisory staff having experience in equipping doctors' offices.

2. Make a tentative list of equipment items you think you'll need — together with cost estimates.

An essential piece of equipment is the perimeter for testing central visual defects. Certain perimeters are equipped with a slate which takes the place of the tangent screen. However, eye men, who like to do refined perimetric measurements, indicated that the older type tangent screen, the large screen, is often better for their purposes. This type can either be purchased or made in accordance with measurements found in texts on perimetry.

A specialized instrument for measuring central fields is the campimeter ($300).

The gonioprism ($60) was considered optional by the majority of respondents. While many eye men did not find this "practical for office use," others

indicated it is "essential for a detailed and more refined examination" in certain types of cases and in studying the anterior chamber angle of the eye.

Illumination

Some form of movable, condensed illumination is needed in the office; one which allows the doctor to have the availability of both hands, instead of tying one up with a pocket light or some other light, is preferable.

Another essential piece of illumination is the transilluminator. This comes in many forms and from many different manufacturers. The physician will select one most suitable and convenient for his purposes.

The tonometer for measuring intra-ocular pressure is essential and indispensable. Average price runs from $25 to $55.

A good, useful piece of equipment (though listed as "optional" by a number of respondents) is an electrical coagulator or desiccator. Such an instrument is useful in removing small lesions about the lids and in electrolytic epilation. Price about $75.

A suggested list of surgical instruments would include: eye scissors, eye forceps, needle holder, eye speculum, lid retractors, chalazion forceps, chalazion curettes, surgical knives, punctum dilators, lacrimal probes, lacrimal irrigating cannulae, mosquito clamps or other type of hemostatic forceps, and bandage scissors.

Other items listed by respondents include eye sutures, ordinary surgical dressings such as gauze and cotton, antiseptics, eye patches and adhesive.

For the removal of foreign bodies a variety of eye spuds should be purchased. All these instruments are made by a number of manufacturers, American and foreign.

Ophthalmologists reported that stainless steel instruments found favor more often than the chrome plated. Though more expensive than chrome, stainless steel "proved more economical"

due to durability over a longer period. The cost for these surgical instruments, depending on make and finish, may vary between $75 and $150.

"Indispensable," according to most ophthalmologists is "a wide variety of medications." A broad group of drops and salves are essential to the care of the various eye conditions met with in the usual office practice. Among these are the miotics and mydriatics, the antiseptics and the anesthetics; and also the emollient drops and salves. A "medium sized" sterilizer is also a must. "It would be false economy to purchase the smaller types of sterilizers," according to one respondent. "Though useful for small items, they are not of any use where a large amount of equipment is to be boiled at one time."

A variety of syringes and needles will be needed. The doctor frequently has to administer various type of medications such as antibiotics and tetanus antitoxin as well as the steroid preparations, to mention a few injectables.

A small refrigerator is needed by the eye man for the storage of his perishable medications. Today, the eye specialist uses many vaccines, biologicals, steroids and antibiotics. Thus, a satisfactory refrigerator is "as essential to the ophthalmologist as to any other practitioner in medicine," said one eye specialist.

According to another: "While most of these things are stable at room temperature, it is better to store such medications under adequate refrigeration." A refrigerator can be purchased for about $125 to $150.

Printing

There are a number of incidental items which must be included in the office equipment budget. One of the most important of these, but often overlooked until the last minute, is "printing." This would include your announcements (to let the other doctors in your community know you're in business) personal cards, letterheads, billheads, case records, bookkeeping forms, etc.

The total expenditure you can expect to make for this type of necessary professional printing will be about $60 to $70. Incidentally, there are firms which make a specialty of supplying doctors' printing needs. Quite often it will save you time and money to order your forms, stationery, and a bookkeeping system from these specialists. In

most cases, you can make all such arrangements by mail.

The foregoing represents the basic needs of the beginning ophthalmologist, according to RESIDENT PHYSICIAN poll. While there are a multitude of other things "which can be poured into the average ophthalmologist's office," reports one man, the selection made in this discussion of essential and borderline equipment comprises an average estimation of that equipment which will be basically useful to the carrying out of a proper eye examination and treatment.

Prices in all cases are for new equipment and give only the approximate range for each category.

The editors have attempted to give our resident ophthalmologist readers an overall view of the cost of outfitting the beginning office in ophthalmology. Many items are omitted. Many offices can be (and are) much more elaborately equipped. Also, special consideration was given to price. In modern day merchandising, credit terms can be made so attractive to the beginning practitioner that in many cases it may be wiser to purchase an income-producing item on credit, rather than to defer it.

We asked each member of the survey group to give an approximate figure for the cost of outfitting his original office. The figure was to be complete, including any items such as typewriters, nurse's desk, nurse's chair, filing cabinet, etc., some of which you may be able to do without.

Most (65%) ophthalmologists reported they had spent under $4000 for equipment. A second group comprising 30%, expended between $4000 and $5000, while the remaining 5% ranged from $5000 up to $7350.

It is well to keep in mind that many forms of financing are available to the beginning specialist. As a general rule, however, your bank and the manufacturer of your equipment offer the most attractive plans.

What's Army Psychiatric Training Really Like?

"I am not a recruiting officer trying to get enlistments. If, however, you are considering going into psychiatry as a specialty, this may give you an idea of the Army program and dispel many of the false ideas about it."

Captain Richard A. Newman, M.C.

To paraphrase Manfred Bleular on schizophrenia, if any one should accuse me of being unbiased about this residency, they would be wrong. I am well satisfied with the program from many aspects.

I came into the Army with serious misgivings and many misconceptions. Those had, unfortunately, prevented me from taking an Army internship. I'd like to mention a few of the ideas I had about the Army and how they have changed.

My biggest fear of the Army was that once I got in I would not be able to get out of the service. I had visions of being caught up in Army red tape and growing old practicing medicine in an unwanted Army uniform. I soon became aware, however, that the Army doesn't want a lot of unhappy doctors avoiding work; after you have completed your obligation, there is no difficulty in resigning.

Another area of rather nebulous concern revolved about

my nurses outranking me. I had some sort of fantasy about standing at attention and saluting every time the nurse walked on the ward.

It has happened, of course, that occasionally my nurses have outranked me, but at no time has the doctor-nurse relationship ever been forgotten. Unlike other hospitals that I have been in, Army nurses don't try to run doctors or assume their ward responsibility.

I'm sure you all know of at least one nurse who thought the young doctor was invading her sanctum sanctorum, and made life miserable for him "defending" her domain. This hasn't happened to me in the Army.

Maybe it's actually because of the occasional rank discrepancy and over-compensation on the part of the nurses, but they have all been of excellent professional competence, and have worked *for* me instead of *against* me.

Rank

Along the same line, many warned me of the strict "pecking order" in the military. Once again I was surprised at what I found. My experience has been that there has been less "rank pulled" in the Army psychiatry residency than in the usual set of Grand Round at any medical school. I have never been lost in the system or just a number. From the first day of the residency program, people listened seriously to what I had to say and even when I was talking without real substance or thought, my views were given consideration and discussed seriously.

Benefits

I'd like to say a word or two about some benefits of the Army program that aren't always stressed but were very important to me. I'm not going to talk about the monetary benefits, or the fact that time is in your favor in regard to board qualifications. There is probably a page advertisement in RESIDENT PHYSICIAN that gives all that information.

My residency is at Walter Reed Army Hospital, a training center, where I work closely with other residents in many fields using and giving consultation freely.

You are wanted in the hospital and you fit into a professional and social group where no one makes you feel as if he was doing you a favor in training you. That means a great deal in psychiatry.

I don't want to give the idea that everything is "peaches and cream." You work and you work hard. Your ideas are considered,

but before they are accepted, they are subjected to thorough scrutiny to see if they will work.

There is competition among the residents but the residency system is columnar and there is none of the viciousness of the pyramidal system. However, if you get inflated with your own importance and ideas, the bubble is soon exploded and you are brought abruptly back to reality.

Program

The residency program is broken into approximately five sections as follows:

- Male ward psychiatry, open and closed, 9 months.
- Female ward psychiatry, open and closed, 6 months.
- Child Guidance Outpatient Clinic, 6 months.
- Neurology, 6 months.
- Outpatient Clinic and Consultation Service, 9 months.

Each man in my class was given an 18-bed closed ward and an open ward when he came into the residency. I remember the first day I was given a set of keys and sent out on that ward of "crazy people" with only my slight medical school psychiatric training to draw upon. The syndrome of acute anxiety was forcibly brought to mind. The next nine months was spent getting rid of my fantasies about psychiatry and myself as a psychiartist.

I began to get a more accurate idea of what terms such as "loss of contact with reality" and "affect" really meant.

Assistance

I wasn't "on my own," of course. I had two personal supervisors, a senior resident and the chief consultant to the Army Surgeon General in Neurology and Psychiatry, seeing me weekly.

The assistant chief of Psychiatry made weekly ward rounds on my patients, followed by an hour of help, support, or castigation as he saw fit.

I could have a complete psychological evaluation for any of

ABOUT THE AUTHOR

Graduating from the University of Illinois in 1956, the author entered the United States Army immediately after his internship at Swedish American Hospital in Rockford, Ill. He is a resident physician in psychiatry at Walter Reed Army Hospital, associated with the Army Institute of Research and receiving training in a specialized milieu therapy ward of schizophrenic patients.

my patients and a social service program to call upon at any time.

Several conferences and seminars were compulsory during this period. An intake conference twice a week was used to review the week's admissions. A two-hour problem conference was held once a week to review a fully worked up diagnostic problem with the help of a visiting consultant.

Supervision of long-term psychotherapy cases is begun early in the first year by a civilian consultant, who is usually a training psychoanalyst from the Washington or Baltimore schools of psychoanalysis.

During the first nine months the exposure is to disease, its diagnosis, and mainly somatotherapies. For three to six months, the resident assists or gives electroconvulsive therapy prescribed by himself or the other residents.

Chemotherapy is used extensively and one is relatively free to pick and choose between the flood of psychotropic drugs on the market.

Occasionally one gets tangled in Government red tape of sanity boards, narrative summaries and Army and Air Force regulations. This is not too often to make much difference and it guarantees that you think through a case at least one time.

Once or twice a month the phone rings and a Congressman on the other end inquires about one of his constituents. I soon learned to answer with: "Department of Psychiatry, Dr. Newman speaking." The best results I ever got with that was, "Oops, that answers my question. Sorry."

Routine

On the women's ward the patients are mostly dependents of military personnel ranging from Private to General. By this time the novelty of being a psychiatrist has worn off, diagnosis is sharpened, and you begin to try

psychotherapy in earnest. A supervisor for this is selected. Intake conference and rounds continue with the chief of Psychiatry.

Now, however, you are more on your own. Ward routine is yours to set. One other resident, our senior nurse, the chief social worker and I began each morning with one-half hour of coffee and talk about the patients. Once a week we had a conference with the ward attendants and aired some of our problem cases with them.

I ran two group therapy programs and essentially an open-door ward. As much as I dislike the term "team" and the connotation of "togetherness" that it carries, things were very pleasant. Our "goofs" were tolerated, and all our ideas honestly tried.

Neurology

On Neurology you are a neurologist, pure and simple; surprisingly enough you act like one, tuning fork and all. I was offered ten weeks at the Armed Forces Institute of Pathology studying neuropathology and neuroanatomy and I took it. (Now a set of lectures in these subjects has essentially been substituted for this.)

A neuroradiology conference meets once a week and civilian consultants come in twice a week. The six months on Child Guidance are considered elective and are given in conjunction with the Army's Child Guidance Clinic and Children's Hospital in Washington, D. C.

Just because the last nine months of the residency are designated for outpatient work doesn't mean that your work with outpatients is limited to that time. I have been carrying two to three outpatients with a therapy supervisor since my first six months of residency and this is not unusual for a resident to do.

Meetings

But there are other things I should mention, i.e., evening seminars, the bane of the resident's wife. The first year is spent in reviewing the literature on each specific disease covering the historical works, diagnosis, characteristics, and therapeutic approach.

The second year, the development of analytic thought is traced and the third year is spent in evaluating the various other schools of psychiatric orientation.

In addition, bi-monthly meetings cover such things as personality theory, the biochemical approach to psychiatry, or guest

speakers on some pet approach to psychiatry. During the week, Walter Reed Institute of Research holds a seminar of the experimental approach to neuropsychiatry and the work done at Walter Reed. Some of the better known work has been on sleep deprivation, peptic ulcer in monkeys under stress, physiological changes in depression, emotions and the limbic system, and eighth nerve studies.

Lectures

A noted child psychiatrist has a diagnostic Child Psychiatry Clinic once a week for all residents. A block of lectures is given each year by the Department of Psychology on testing. And, starting this year a weekly seminar for resident's research projects is being given. One is also expected to see patients.

I have always been suspicious of lists of programs and activities discussed as part of a training program. It usually turns out that someone sat down and searched his mind for glowing descriptions of passing catheters and starting I.V.'s and came up with something like "training in essential technical aspects of medicine." Because of my own scepticism I felt it necessary to mention this before I proceded to go right on and make more lists. I think it is also necessary to mention that I'm really not straining to find them.

Research

There are a lot of opportunities to do additional work in the residency, if one can find the time. And one can do as much as he likes, once again, if he can find the time.

Every resident is expected to do some sort of research under supervision. But the rest is elective. Two to six weeks can be spent in psychology just doing testing, or in neuropathology at the Armed Forces Institute of Pathology.

The concept of milieu therapy that is spreading over the country has been extensively studied by the Army and now a training ward has been set up at Walter Reed to train physicians, nurses, and technicians so that they may establish similar wards elsewhere. If the resident wants to be analyzed at his own expense the time for it is given to him. Occasionally the Army will accept the expense for this, but only very occasionally.

One more comment about the residency program, and it may be the most important. It concerns the variety of patients and the

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For hemorrhoids, proctitis and pruritus ani, *start therapy* with ANUSOL-HC—2 suppositories daily for 3 to 6 days—to reduce inflammation, relieve pain and itching, and shorten total treatment time. *Maintain patient comfort* with regular ANUSOL—1 suppository morning and evening and after each evacuation to prevent recurrence of symptoms. Supplement with Anusol Unguent as required.

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places they are contacted. I sat down and reviewed the patients I saw in the first nine months of residency for social and economic level, age, race, and type of illness. I did this because there is a tendency to think of the Army as a group of callow boys and tough sergeants, and of Army Psychiatry as dealing with bad boys and bedwetters. In those nine months I had 103 patients for closed and open ward care. Of these, 20 were Negro and 83 Caucasian. I saw 46 enlisted men; 25 sergeants; 3 warrant officers, 13 officers, from second lieutenant through captain; and 16 officers from major through colonel.

Their educational levels varied from fourth grade education through Ph.D. and M.D.

Chart

A chart shows my patient distribution as to diagnosis. The groups of 13 character behavior disorders and 12 personality disorders are especially worthy of note. Many residents never see these people because they don't usually require hospitalization and they don't seek psychiatric care voluntarily. In the Army program, as in any other community practice, one is faced with their social and private problems.

My youngest ward patient was 15 and the oldest was 66, with a smooth distribution curve between these two extremes. I've had patients from the U. S., Japan, Germany, France, Pakistan, Iran, Yugoslavia, Puerto Rico, and China. During the residency and after it, patients are seen in Mental Hygiene Clinic,

PATIENT DISTRIBUTION

1. SCHIZOPHRENIA	35
Paranoid	27
NEC	7
Catatonic	1
2. MANIC DEPRESSIVE	2
3. PSYCHOTIC DEPRESSION	4
4. PSYCHONEUROTIC	26
Anxiety	7
Obsessive-Compulsive	1
Dissassociative Reaction	2
Conversion Reaction	2
Neurotic Depression	11
Psychogenic Asthenia	3
5. CHARACTER BEHAVIOR DISORDER	13
Emotional Instability	5
Passive Aggressive	7
Passive Dependent	1
6. PERSONALITY DISORDERS	12
Schizoid	5
Paranoid	1
Inadequate	1
Homosexual	2
Alcoholics	2
Addicts	1
7. ORGANIC BRAIN DISEASE	2
8. ACUTE MALADJUSTMENT	6
9. NO DISEASE	3

asthmatic...but symptom-free

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ONE TEDRAL TABLET taken at the *first* sign of an attack relieves congestion and constriction within fifteen minutes and protects for as long as four hours. For prophylaxis or when attacks are frequent, prescribe one or two tablets q.4h. For children 6 to 12 years old, half the dosage.

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on consultation, in psychiatric wards, in disciplinary barracks, and child guidance clinics.

Maybe I'm belaboring a point when I say that I can't think of any other situation in which a psychiatrist might find himself. He is ready to practice either as a soldier or as a civilian, with competence.

Favorable

If the tone of this article has seemed generally favorable it should not surprise you, because I have already said I enjoyed it. You should, however, realize that I don't want to be working with people antagonistic towards me for misleading them, so I've tried to be honest.

I'm going to stick my neck out and hope it doesn't result in too much extra work. If you still have questions but for some vague reason don't want to write to the Surgeon General and you are still somewhat wary of Army psychiatric training, I'll be glad to try and answer any mail sent to me at Walter Reed Army Hospital. To go one step further, I won't even pass your name through regular channels.

"Still bothered by that constipation, eh Mr. Kiel?"

new therapeutic light on "sinus" headache

"sinus" or frontal headache and congestion—whether from true sinusitis or rhinitis—yield promptly to Sinutab. In therapy or prophylaxis Sinutab rapidly and effectively aborts the pain, decongests the mucosa and relaxes the patient. Verify the value of Sinutab for yourself: you *and* your patients will be pleased.

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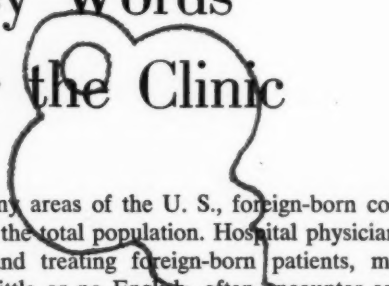
Key Words for the Clinic



In many areas of the U. S., foreign-born comprise a large part of the total population. Hospital physicians when examining and treating foreign-born patients, many of whom speak little or no English, often encounter serious difficulty in communicating even the most routine request or direction. The result is not only frustrating for doctor and patient, but a misunderstanding can endanger the proper care of the patient. To ease the patient's anxiety and assist the physician in conducting an accurate examination and history-taking, RESIDENT PHYSICIAN has prepared this guide to commonly-used medical directions, questions and answers, with translations into various foreign languages.

Using the language guide

Keep this language guide open in front of you while attending your patient. If a word doesn't seem to be understood, repeat it a few times slowly; vary the pronunciation slightly until the patient indicates his comprehension. The fact that you are trying to speak to him in his native language will cause your patient to be more relaxed and responsive. Grateful for your effort, he will be anxious to do everything he can to comprehend and convey accurate, precise information.

FOR EXAMINATION OF

Italian-Speaking Patients

Basic rules of pronunciation

1. The sound of vowels is constant with the exception of e which has two sound values.
   a—*ah*
   e—*eh*
   e—*ay* (generally used in word endings)
   i—*ee*
   o—*oh*
   u—*oo*

2. The sound of consonants varies depending upon the consonant vowel combination.

   C before a, o and u, is pronounced as the C in *cat.*

   C before e and i takes the sound of CH in *chair.*

   G follows the above rules also; before a, o and u, G is "hard" pronounced like G in *go.* Before e and i, G becomes G as in *gentle.*

   However, both C and G are pronounced "hard" before e and i when the letter H appears between the consonant and vowel. Thus, CH in ocCHio is pronounced as the English *k*, and Pinocchio becomes *pee-noh-kee-oh.*

   GU is always pronounced *goo* as in *goose.*

   GL is pronounced as *l,* the *g* is silent.

   GN is pronounced the same as the *ni* in *onion* and *senior.*

   SC and SCH have the ess sound coupled with C and CH and the pronunciation follows the rules for C and CH (see above).

   One variation: SC before e or i becomes sh as in *sheep.*

   R is trilled at tip of tongue.

   Z is like *tz* in *tzar.*

   QU is pronounced as it is in English.

3. Italian words, generally, are pronounced with the accent on the second last syllable. In words of only two syllables, the first syllable is usually emphasized.

4. Plurals do not end in s as in English, French and Spanish. Masculine gender plural nouns usually end in i, while feminine plural nouns generally end with e.

Anatomical terms

head—testa or capo	neck—collo
eye(s)—occhio (occhi)	chest—petto *or* torace
ear(s)—orecchio (orecchi)	breast—seno
nose—naso	heart—cuore
mouth—bocca	lungs—polmoni
teeth—denti	shoulders—spalle
tongue—lingua	back—schiena
throat—gola	arm(s)—braccio (braccia)
finger—dito	hands—mani
leg(s)—gamba (gambe)	rectum—retto
feet—piedi	buttock—natica
stomach—stomaco	womb—utero
bladder—vescica	

Courtesy phrases

Note: Normal courtesy requires the frequent use of the titles *Signore* (Sir), *Signora* (Madam) and *Signorina* (Miss). For the sake of brevity these titles are used only in the first three phrases below.

Good morning, Sir	Buon giorno, signore *boo ohn jeeohrnoh seenyohray*
Good afternoon, Madam	Buona sera, signora *boo ohna sayrah seenyohrah*
Good night, Miss	Buona notte, signorina *boo ohna nohtay, seenyohree-nah*
Please	Favorisca *or* per piacere

(In giving directions to patients, *favorisca* or *per piacere* should be used to begin each statement.)

Please sit down	Favorisca s'accomodi
How are you?	Come sta lei
Very well, thanks	Benissimo, grazie
Do you understand	Comprendi, (capisci)
I (do not) understand	(non) capisco
Excuse me	Scusi
Pardon me	Perdoni
Very good	Buonissimo
Today	Oggi
Tomorrow	Domani
Yesterday	Ieri

General questions

do you feel sick	vi sentite male
do you have pain	vi fa male
—much pain	—molto male
—mild pain	—male poco
where	dove
here	qui
when	quando
how many years	da quanti anni
how many days	da quanti giorni
how many hours	da quante ore
how many times	quante volte
how old are you	quanti anni avete
where were you born	dove siete nato

Directions to patients

do as I do	fate come faccio io
relax	calmatevi
relax more	calmatevi di piu
open your mouth	aprite la bocca
open your eyes	aprite gli occhi
breathe deeply	respirate profondamente
breathe through your mouth	respirate per la bocca
hold your breath	trattenete il respiro
push	spingete

cough	tossite
please don't move	per piacere, non si muova

Diseases

measles	morbillo
scarlet fever	scarlattina
chicken pox	varicella
small pox	vaiuolo
pneumonia	polmonite
typhoid fever	febbre tifoidea *or* tifo
enteritis	enterite
U.R.I.	raffreddore

Systemic inquiry

Head	
trauma	trauma
unconscious	incosciente
did you faint	siete svenuto
are you dizzy	vi sentite il capogiro
headache	mal di capo
Eyes	
sight	vista
clear vision	buona vista
near	vicino
far	lontano
Ears	
he is deaf	egli e'sordo
noise in the ears	rumore alle orecchie
Nose	
coryza (head cold)	coriza (raffreddore di testa)
did you have a nosebleed	vi ha sanguinato il naso
Throat	
do you often have a sore throat	vi sentite il mal di gola spesso
Cardio-respiratory	
do you tire easily	vi stancate facilmente
are you short of breath	vi sentite mancare il respiro
does you heart beat fast	vi batte il cuore presto
do your feet swell	vi si gonfiano i piedi

do you have pain in the chest	avete dolori al petto
—sharp pain	—dolore acuto
—dull pain	—dolore vago
—when you breathe	—quando respirate
do you cough	tossite
do you spit	sputate
sputum	sputo
bloody sputum	sputo insanguinato
have you lost weight	siete diminuito di peso
pound	libbra
does someone in your family have a cough	C'e'qualcuno nella vostra famiglia che tossisce

Gastrointestinal

do you have a good appetite	avete un buon appetito
do you have a poor appetite	avete poco appetito
are you nauseated	vi sentite nauseato
were you nauseated	vi sentivate nauseato
do you vomit	vomitate
do you have diarrhea	soffrite di diarrea
are you constipated	siete stitico
feces	feci
black	nero
white	bianco
yellow	giallo
brown	bruno
bloody	insanguinato
do you have cramps	avete dei crampi
after meals	dopo e mangiade (*or* pasto)
before meals	prima dei mangiade
did you take a laxative	avete preso un lassativo
did you take castor-oil	avete preso dell'olio di ricino

Genitourinary

urine	urina
do you get up at night to urinate	vi alzate la notte per urinare
does it burn	vi sentite bruciore

chills	brividi di freddo
fever	febbre

Obstetrics and gynecology

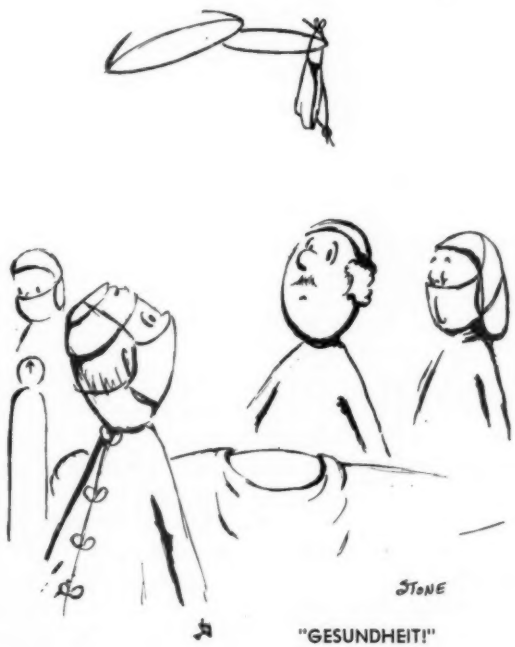
at what age did you begin to menstruate	a quale eta' vi sono incominciate le menstruazioni
how many days do you flow 1 to 10	per quanti giorni avete il flusso una, due, tre, quattro, cinque, sei, sette, otto, nove, dieci
do you have discharge	scarciate (avete dello scarcio) perdite
when was your last menstrual period	quando avete avuto l'ultimo periodo menstruale
are you pregnant	siete incinta
do you have pain with your period	i vostri periodi sono accompagnati da dolori
how many times have you been pregnant	quante volte sieta stata incinta
how many children have you had	quanti figli avete avuto
how much did the largest weigh at birth	quanto pesava il piu grande dei vostri bambini al momento della nascita
what was the duration of labor	quanto sono durate le doglie del parto (quanto dura)

Pediatrics

did you have trouble with the child's delivery	si sono stati disturbi durante il parto
how are the child's stools	come sono gli escrementi del bambino*
constipated	stitico**
diarrhea	diarrea
how many in one day	quante volte in un giorno
does the child eat well	il bambino mangia bene
any vomiting	c'e del vomito
does the face turn blue	il bambino* diventa paonazzo in viso

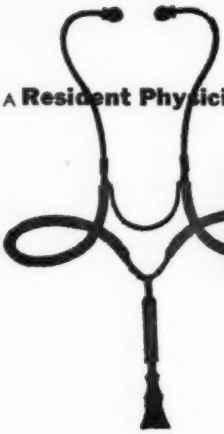
does the child seem tired	il bambino* sembra stanco
does it hurt	fa male
it won't hurt	non fa male
it will be finished in a minute	in un minuto sara tutto finito
do you want a piece of candy	vuoi una caramella
did you take the temperature	avete misurato la temperatura
what was the temperature	che temperatura avete
what a big, handsome boy	che bel ragazzo
what a beautiful little girl	che bella ragazzina
baby	bambino*
good	buono

* bambina, if female child. ** stitica, if female child.



"GESUNDHEIT!"

A **Resident Physician** MONTHLY FEATURE



Mediquiz®

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 182.*

1. The pancreatic or intestinal basis for steatorrhea may be established by:

A) Biliary drainage for cholesterol and bilirubinate crystals.

B) Determination of the effect of oral calcium-45 on serum calcium.

C) Determination of the Na^+ and Cl^- content of the sweat.

D) Comparison of the absorption of I^{-131} oleic acid and triolein.

E) Determination of urinary 5-hydroxy-indole-acetic acid after a banana diet.

2. Which of the following statements about the edema occurring in patients with nephrosis is correct?

A) The edema is definitely due to hypoproteinemia.

B) The edema may decrease with low levels of serum albumin.

C) The edema responds only to intravenous albumin.

D) The edema is definitely due to sodium retention.

E) The edema is not lessened by mercurial diuretics.

3. An unfavorable sign during the course of active tuberculosis is:

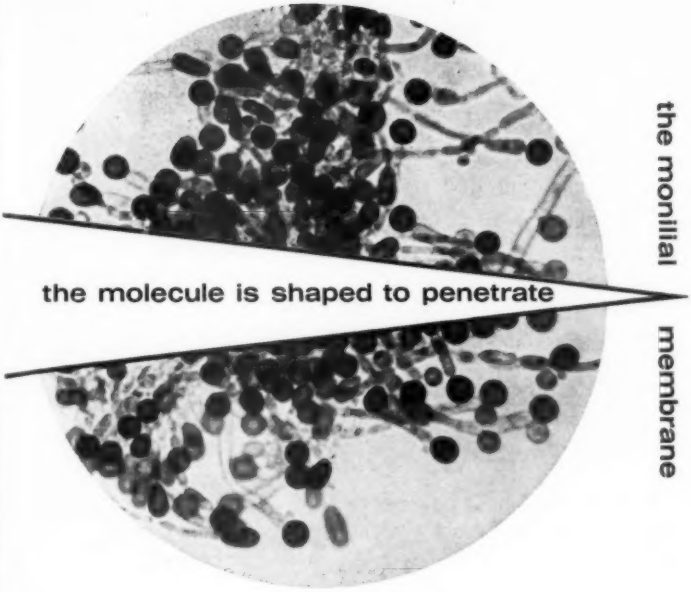
A) The appearance of cryoglobulins.

B) An increase in red cell fragility.

C) A fall in serum calcium.

D) Progressive lymphocytosis.

E) Increasing monocytosis.



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soothing, odorless, white, vaginal fungicide

- Exceptional fungicidal activity
- Enthusiastic patient acceptance
- Outstanding clinical results

Lapan, B.: Am. J. Obst. & Gynec. *78*:1320, 1959.

Ortho

4. In general practice, the most reliable single diagnostic procedure in the evaluation of a patient for pheochromocytoma is the:

A) Phentolamine test.

B) Injection of .01 - .025 mg. of histamine phosphate intravenously.

C) Injection of regular insulin in a fasting state until the blood sugar is less than 50 mg./100 cc.

D) Cold pressor test.

E) Determination of 24-hour catechol amine excretion.

5. Multiple small pulmonary arteriovenous fistulas may occur in:

A) Silicosis.

B) Tuberculosis.

C) Berylliosis.

D) Cirrhosis.

E) Sarcoidosis.

6. Which one of the following factors responsible for increased ventricular output is *not* accompanied by a widened pulse pressure?

A) Complete heart block.

B) Arteriovenous aneurysm.

C) Iron deficiency anemia.

D) Thyrotoxicosis.

E) Exercise.

7. Cortisone will *not* lower hypercalcemia due to:

A) Sarcoidosis.

B) Multiple myeloma.
C) Hyperparathyroidism.
D) Metastatic disease.
E) Milk-alkali syndrome.

8. The normal mean value for vitamin B_{12} in the serum, expressed in micromicrogm./ml., is:
A) 110.
B) 470.
C) 720.
D) 1130.
E) 1480.

9. Plasmin is a:
A) Salt-free plasma.
B) Plasma expander.
C) Fibrinolytic enzyme.
D) Component of the first stage in the clotting mechanism.
E) Component of the second stage in the clotting mechanism.

10. The ideal method of dividing an anal sphincter for removal of a fistula in the anal region is:
A) A double incision laid carefully parallel, about one inch apart in either side of the fistula.
B) One posterior raphe incision perpendicular to the line of muscular fibers.
C) En bloc removal of a portion, always posteriorly, with swinging of sartorius transplant.
D) An oblique incision cutting muscle fibers at different lengths.
E) Elevation of sphincters and levators from ischial origins.

11. The use of radioactive I^{-131} tagged albumin to measure plasma volume is based upon the:
A) Affinity of I^{-131} for Evans blue dye.
B) Differential ability of I^{-131} to tag albumin and globulin.
C) Plasma oncotic pressure gradients.
D) Rapid half-life of I^{-131}.
E) Isotope dilution technique.

12. Capillary angioma is most commonly situated in the:
A) Skin.
B) Nasal mucous membranes.
C) Lips.
D) Tongue.
E) Liver.

13. Most of the intracranial tumors found in children are located in the:
A) Third ventricle.
B) Cerebellar fossa.
C) Temporal lobe.
D) Frontal lobe.
E) Suprasellar region.

(Answers on page 182)

What's the Doctor's Name?

Appointed Health Commissioner of Chicago in 1922, after his work in a typhoid epidemic there, he directed successful campaigns against infant and maternal mortality, diphtheria and syphilis. But in 1927 he was fired by Mayor William Thompson for refusing to include political campaign literature in mailings of health pamphlets to mothers of newborn infants.

The following year he ran for County Coroner, winning by a million votes. Three years later he regained the position of Health Commissioner and subsequently was elected president of the Board of Health, a post he held until his death on August 15, 1960, at 78.

His earliest health achievement was the virtual eradication of bone tuberculosis, between 1922 and 1926, by convincing milk processors to install proper equipment in pasteurizing plants, and

by directing dairymen to slaughter 400,000 diseased cows.

In the 1956 Chicago polio epidemic, he stepped up the campaign for complete inoculation when he discovered that victims were those who did not have the full series of injections.

He was a controversial, dramatic figure, accused at various times of using his post to further a milk monopoly, malfeasance, (in a horsemeat scandal) and waiting too long to tell physicians that amoebic dysentery was the cause of a Chicago epidemic. He was cleared of all charges.

He wrote a number of books on baby care, and his syndicated column appeared in 500 newspapers.

He was a president of the American Public Health Association and a senior surgeon in the U. S. Public Health Service.

A life-long Episcopalian, he became interested in the Roman Catholic Church two months before his death and received its last rites. The Chicago City Council called a special meeting to memorialize his passing. Can you name this doctor? *Answer on page 182.*

VIEWBOX DIAGNOSIS

(from page 25)

FIBROUS DYSPLASIA

Note the marked enlargement of all the bones with fibrous replacement. Note the thinning of the cortex in the upper end of the right fibula.

●

MEDIQUIZ ANSWERS

(from page 176)

1(D), 2(B), 3(E), 4(E), 5(D), 6(C), 7(C), 8(B), 9(C), 10(B), 11(E), 12(A), 13(B).

●

WHAT'S THE DOCTOR'S NAME

(Answer from page 180)

HERMAN NIELS BUNDESEN

●

RESIDENT RELAXER

(puzzle on page 29)